APS Healthcare

Final Report

CAEQRO Report, FY13-14

San Diego

Conducted on

March 14, 2014

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❖INTRODUCTION❖

BACKGROUND AND METHODOLOGY

The California Department of Health Care Services (DHCS) is charged with the responsibility of evaluating the quality of specialty mental health services provided to beneficiaries enrolled in the Medi-Cal managed mental health care program.

This report presents the fiscal year 2013-14 (FY13-14) findings of an external quality review of the San Diego County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, March 14, 2014.

Based upon an amended contract due to a budget reduction for FY13-14, DHCS and CAEQRO identified fifteen MHPs which would receive a less intensive review. This is intended to result in somewhat less robust pre-review documentation and a shorter report following each review, with all such reviews limited to one day. The fifteen MHPs identified were those with the highest total performance in the Key Components, organized by quality, access, timeliness, and outcomes. Therefore, reports for these fifteen reviews will not include ratings on those elements.

The CAEQRO review draws upon prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Discussions associated with the four domains: quality, access, timeliness, and outcomes. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups and other stakeholders which inform the evaluation within these domains.
- Analysis of Medi-Cal Approved Claims data
- Two active Performance Improvement Projects (PIPs) – one clinical and one non-clinical
- Two 90-minute focus groups with beneficiaries and family members
- Information Systems Capabilities Assessment (ISCA) V7.3.2

❖FY13-14 REVIEW FINDINGS❖

STATUS OF FY12-13 REVIEW RECOMMENDATIONS

In the FY12-13 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY13-14 site visit, CAEQRO and MHP staff discussed the status of those FY12-13 recommendations, which are summarized below.

ASSIGNMENT OF RATINGS

- Fully addressed – The issue may still require ongoing attention and improvement, but activities may reflect that the MHP has either:
  - resolved the identified issue
  - initiated strategies over the past year that suggest the MHP is nearing resolution or significant improvement
  - accomplished as much as the organization could reasonably do in the last year

- Partially addressed – Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues

- Not addressed – The MHP performed no meaningful activities to address the recommendation or associated issues.

KEY RECOMMENDATIONS FROM FY12-13

- Develop and implement a strategy to reduce the time needed for IS authorization and training of new staff:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed
  - The Optum Administrative Service Organization (ASO) contract was expanded in February 2014 to add more trainers to support additional computer classes, reducing wait times for training new staff.
  - The MHP is pursuing a strategy to implement a Cerner Remote Hosting solution by December 2014. This would remove Hewlett Packard as a third party and the time needed for IS authorizations would decrease.

- Establish a stakeholder driven process including the line staff, supervisors and contract providers to streamline the current documentation requirements and intake processes so as to prioritize treatment over documentation and provide hands-on training to line staff on the same:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP formed workgroups, which included membership from contract provider agencies, to review the behavioral health assessment utilized in both children and adult services. The assessments were revised to be more logical and streamlined based upon the recommendations from these workgroups. The assessments are in the process of being updated in the Electronic Health Record (EHR).
  - The MHP also developed a High Risk Assessment with the input of stakeholders. This tool is used to identify, assess and create a plan for high risk consumers, and is designed to be used at intake as well as any necessary juncture thereafter.
  - During the past year, the MHP began a related project with Family and Youth Partners. Quality Management (QM) staff, Family & Youth Program line staff, supervisors and others in leadership met to discuss roles within the treatment teams and to clarify documentation standards. Several deliverables will result from these meetings, including a training to help clarify billing and documentation requirements for Family & Youth Partners. The Organizational Provider Operations Handbook is also being updated to reflect key information related to consumer run programs and peer and family member staff.

- Enhance the QI Work Plan by establishing measureable and time-bound performance improvement goals:
  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The updated Quality Improvement (QI) Work Plan contains an increased number of goals with measurable indicators, although many continue to have no expressed target date. Newly quantified goals for which baseline information is not available require capturing baseline data to determine the current status of the goals.
  - CAEQRO recommends continuing to refine the QI Work Plan to reflect the many performance improvement initiatives underway. Embedding baseline data, where it exists, within the goal statement allows current performance relative to the stated goal to be readily apparent. Utilizing internal and/or external benchmarking for goals will increase the meaningfulness of the selected goals.

- Formalize a system-level tracking mechanism to capture children's psychiatry access and timeliness as well as tracking of missed appointments within the children's system:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP developed a new report in FY13-14 to track and trend on a monthly basis

the timeliness of service to children psychiatry providers. Wait times longer than thirty days require narrative explanation from the provider detailing factors involved in the delay in service. The MHP submitted a sample report from March 2014. Of the approximately 48 children's psychiatry providers represented, one provider had wait times that exceeded thirty days.

- The MHP provided a cumulative appointment no show rate of 3% for FY 12-13. No shows to date for FY 13-14 were not provided. This data was not stratified by demographics or program, and was likely an underrepresentation of the actual no show rate. The MHP continues to refine its timeliness data collection and tracking methods.

- Examine whether processes can be adjusted to use the IS to inform clinicians in real time of their consumers' admissions to inpatient settings:
  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - Optum staff continues to enter psychiatric inpatient admission, discharge, and transfer information for Medi-Cal beneficiaries into Cerner. This information may not be provided in a timely manner, because it becomes available only when the receiving hospital requests authorization.
  - Discussions with hospital partners continue regarding coordination of care information being exchanged electronically.
  - The MHP continues to review Cerner report templates to determine how to most effectively provide data and information to clinicians as quickly as possible.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

Changes since the last CAEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including those changes that provide context to areas discussed later in this report.

- Progress continues on the integration of the MHP and Alcohol and Drug Services (ADS) into a behavioral health (BH) services division at both the program and policy level. Quality improvement, cultural competency and trauma-informed care efforts are being extended to the whole BH division. Integration of the MH and ADS advisory boards is expected by January 2015.
- The MHP's long-term clinical director retired and a new clinical director was hired. Under the new clinical director, the MHP is exploring the possibility of becoming a Welfare and Institutions Code Section 5270-authorized county to enable the MHP to assist a consumer in stabilizing and avoiding pursuing unnecessary conservatorship.

- The MHP is participating in the three-year Cal MediConnect demonstration project for dual eligible (Medicare & Medi-Cal) beneficiaries. Participants receive coordinated medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system. The MHP's partners include Care1st, Community Health Group, Health Net Community Solutions, Molina Healthcare, and Optum Health.
- The MHP implemented a smooth transition of the behavioral health benefit of Healthy Families to Medi-Cal. Final report to the State indicated 1,346 unduplicated mental health beneficiaries for CY 2013.
- The MHP received the authority to expand its voluntary assisted outpatient treatment In Home Outreach Teams (IHOT) to all six regions of the county. The MHP has also developed a feasibility analysis of implementing Laura's Law locally, and continues to provide quarterly reports to the Board of Supervisors regarding this issue. Additionally, the MHP has committed to expanding services on the acute end of the spectrum for both adults and youth: a three-bed short-stay crisis respite facility for youth was opened and a crisis residential facility for adults is planned for the one remaining region that lacks such a facility at this time.

Performance & Quality Management Key Components

CAEQRO's overarching principle for review emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management – an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies which support system needs – are discussed below.

Quality

CAEQRO identifies the following components of an organization that is dedicated to the overall quality services. Effective quality improvement activities and data-driven decision making requires strong collaboration among staff, including consumer/family member staff, working in information systems, data analysis, executive management and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

- The MHP submitted an updated Quality Improvement Work Plan as well as an exemplary evaluation of the previous year's Work Plan. As stated earlier, the QI Work Plan now consistently contains measurable goals. However, it

could benefit from a clear inclusion of baselines (where they exist) and time bound goals. The MHP's Quality Review Council (QRC) met six times during the past calendar year and added a representative from ADS staff. A review of the QRC activities as documented in the minutes shows a decreasing amount on input and activity from the participants throughout the course of the year; the QRC appears to have a less significant role in driving system improvement compared to prior years.

- The MHP produces many valuable data reports that serve both as a basis for decision making and to evaluate the outcomes of programs. Examples include longstanding reports such as the combined annual Data Book and the triennial Disparities Report, as well as the newer reports evaluating outcomes associated with the IHOT team, the Hope Connections project, healthcare integration efforts, jail follow up efforts and others.
- The QI Performance Improvement Team created a new biannual HHSA-BHS Research Bulletin, a publication that highlights mental health services research conducted by principle investigators from the University of California San Diego (UCSD). The publication highlights both newly-published work and ongoing studies that are recruiting human subjects.
- Medi-Cal claims submissions and claim volume were consistent and generally timely during the past year. The MHP's denial rate (2.5%) for FY12-13 was lower than statewide denial rate of (4.1%) for the same period.
- Contracting Officer Representative (COR) perform as critical liaisons between the MHP and contract providers. Based on provider interviews there is a perception that COR turn-over along with the recent integration of MH and ADS divisions has resulted in inconsistent communication, which in turn requires more contractor staff time and effort to resolve issues that were previously routine.
- Consumer and family member staffing has quadrupled between 2007 and 2013. The MHP and contract providers employ 124 FTE Peer Support Specialists and 86 Family Support Partners. Training opportunities continue through NAMI, the Community Academy and the Youth and Family Roundtable.

Access

CAEQRO identifies the following components as representative of a broad service delivery system which provides access to consumers and family members. Examining capacity, penetrations rates, cultural competency, integration and collaboration of services with other providers form the foundation of access to and delivery of quality services.

- The MHP has four threshold languages: Spanish, Vietnamese, Tagalog and Arabic. Access to services by these populations is monitored through the disparities report and in an informal way by CORs. Despite tracking multiple variables, important metrics such as timeliness to first service by preferred language as well as service mix and retention rates are not tracked by language, race or ethnicity. Certain system changes, such as the introduction of collaborative charting, are only available for consumers who receive services in English, and service plans are also not readily available to LEP consumers.
- The Progress Towards Reducing Disparities Report is published every three years, with the last available report produced in FY11-12 trending eight years of data from FY01-02 through FY 09-10. This report examines the disparities between the consumers who receive treatment versus the eligible population along the domains of race/ethnicity, age and diagnostic patterns. The report does not look specifically at services by language, nor does it explore the mix of services received by those domains.
- The MHP is focused on projecting the need for increased staffing and capacity based upon both anticipated increased demand and changes in population characteristics. An example is the need for increased bilingual/bicultural staffing as in the northern part of the county as the racial/ethnic composition of the eligible residing in those areas change. The MHP is also aware of the increased use of Vietnamese/Cambodian interpretation due to staffing losses. Some MHP estimates suggest service capacity will need to expand by 12% by 2020.
- In 2013 the MHP launched a Faith Based Initiative to develop a partnership with faith African American and Latino congregations in the Central and North Inland regions. The MHP hosted a breakfast meeting in each region; each meeting included over 150 participants representing individuals from faith based communities, MHP programs, advocates, consumer and family members, community stakeholders, advocates and non-profit organizations. The MHP created resource compendiums following each of the events that highlighted the themes of education/training, partnership, collaboration and funding/resources, and outlined next steps for ongoing deepening of working relationships.
- The Cultural Competence Academy is currently training its third cohort. The first two cohorts focused on African American and Latino culture respectively. The current cohort curriculum is on the Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer/Questioning (LGBTIQ) population, with a selected emphasis on either TAY populations or across the lifespan. The training culminates with a capstone project that trainees present as part of a graduation ceremony. A total of 222 individuals have attended training to date.

- The MHP contracted with the San Diego Workforce Partnership to develop a five-year employment strategic plan. This plan is to include development of an array of employment opportunities for the Transition Aged Youth, adults and older adults who receive MHP services.
- Collaboration with various healthcare partners continues to appear strong and communication in this large system that relies heavily upon collaborative efforts. In particular the MHP partnership to implement Cal MediConnect Program is noteworthy. The partners include Care1st, Community Health Group, Health Net Community Solutions, Molina Healthcare, Optum Health, and San Diego Behavioral Health Services.
- The *Katie A.* settlement implementation team has been meeting weekly for 18+ months, and recently changed to biweekly meetings. Representatives for the MHP, CWS, QI, and foster youth and families comprised the implementation team and smaller work groups that had originally worked on topics such as Child and Family Teaming, data, assessment and training. Locally, *Katie A.* services are known as "Pathways to Wellbeing." The MHP began with identifying subclass members among the 420 individuals who were receiving services from the Residential Unit—youth living either in group home or foster family placements. Creation of a screening tool and hiring and training significant numbers of new staff under the new FY budget have slowed the roll-out of subclass identification to the remainder of the open CWS cases; however this is anticipated to begin in July 2014.

Timeliness

CAEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

- The MHP does not set a standard wait time expectation for wait time to first appointment across the system; rather, it maintains different wait time goals based upon age group and geographic region. Measurements are to first offered appointment rather than first completed service. Despite the lack of uniformity, wait times are tracked closely, with appointments falling outside of the norm documented and discussed with CORs and in management meetings. At the request of the Board of Supervisors (BOS), the MHP has been trending monthly wait times to first service and first psychiatry for adults and to first service for youth. Wait times have trended downward (shorter wait times) over the past five years.
- The MHP does not specifically monitor timeliness by language preference.

The MHP notes that as it has moved towards walk in services, the MHP has changed the specifics of the interpretation contracts to reflect this change. Additionally, MHP directly operated and contract providers maintain current lists of language capacity which are reviewed routinely.

- The MH Board also pays close attention to wait times, and issues such as psychiatry staff turnover, recruitment issues around linguistic targets, and mitigating efforts such as the use of telepsychiatry, use of interpreters, and deployment of NP staff are discussed.
- The MHP does not maintain an official standard for timeliness to psychiatry, although 30 days is understood to be the goal. Length of time to psychiatry is reported for adults as averaging 4.6 days (2.2 days FFS) with zero to 47.8 days as the range. The MHP began internal tracking of wait times to children's psychiatry appointments in July 2013 and report an average nine day wait time for the first nine months of the FY.
- The MHP did not provide any tracking of timeliness to urgent conditions. The MHP maintains an informal standard of 72 hours to respond.
- The MHP maintains a goal of providing post-psychiatric hospitalization follow up within three days of discharge and tracks this timeliness by service type. The MHP meets this goal slightly less than half of the time (47%) for those discharges that receive follow up (60%). The MHP also tracks readmission rates.
- The MHP states it does not routinely track no show data, but provided 3.9% as the no show rate for scheduled appointments in FY12-13. The MHP acknowledges that this data likely reflects an incomplete no show picture.

Outcomes

CAEQRO identifies the following components as essential elements of producing measurable outcomes for beneficiaries and the service delivery system. Evidence of consumer run programs, viable performance improvement projects, consumer satisfaction surveys and measuring functional outcomes are methods to evaluate the effectiveness of a service delivery system as well as identifying and promoting necessary improvement activities to increase overall quality and promote recovery for consumers and family members.

- The MHP utilizes multiple outcomes instruments for its populations served. The Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ) are used, as well as the Milestones of Recovery Scale (MORS) and the Level of Care Utilization System (LOCUS). For children's outcomes, the MHP utilizes the Child and Adolescent Measurement System (CAMS), the Children's Functional Assessment Rating

Scale (CFARSP), and the Youth Services Survey (YSS). The MHP added the use of the Personal Experience Screening Inventory (PESQ), a substance abuse screener for youth aged 12-18. The MHP is not currently planning to implement additional tools in anticipation of the upcoming statewide performance outcomes system for EPSDT youth.

- Outcomes are used on an individual consumer/clinician basis for treatment planning and to track readiness for treatment graduation. Outcomes are provided to programs along with benchmarks from similar programs. The MHP's eventual goal is to track the impact of moving to a short-term treatment model on those parts of the system for which it is relevant, namely, the Children, Youth and Families System of Care.
- The MHP submitted a clinical PIP exploring best practices for reducing psychiatric readmission rates in partnership with local hospitals. The nonclinical PIP outlined efforts to introduce elements of trauma-informed care into an outpatient clinic setting. Details for both PIPs can be found below.
- The MHP participated in the Performance Outcomes Quality Improvement (POQI) survey as required by DHCS. The MHP's research partners from the University of California San Diego (UCSD) analyzed the 1,618 completed surveys by level of care. Generally respondents endorse high levels of satisfaction, however the MHP has used survey findings in decision making regarding the use of Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding as well as in contracting decisions.

❖CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES❖

Information to support the tables and graphs, labeled as Figures 5 through 15, is derived from four source files containing statewide data.[1] A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – follow as an attachment. The MHP was also referred to the CAEQRO Website at www.caeqro.com for additional claims data useful for comparisons and analyses.

RACE/ETHNICITY OF MEDI-CAL ELIGIBLES AND BENEFICIARIES SERVED

The following figures show the ethnicities of Medi-Cal eligibles compared to those who received services in CY12. Charts which mirror each other would reflect equal access based upon ethnicity, in which the pool of beneficiaries served matches the Medi-Cal community at large.

Figure 5 shows the ethnic breakdown of Medi-Cal eligibles statewide, followed by those who received at least one mental health service in CY12. Figure 6 shows the same information for the MHP's eligibles and beneficiaries served. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP's approved claims worksheets.

[1] Percentages may not add up to 100% in some of the figures due to rounding of decimal points.

Figure 5a. Statewide Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY12

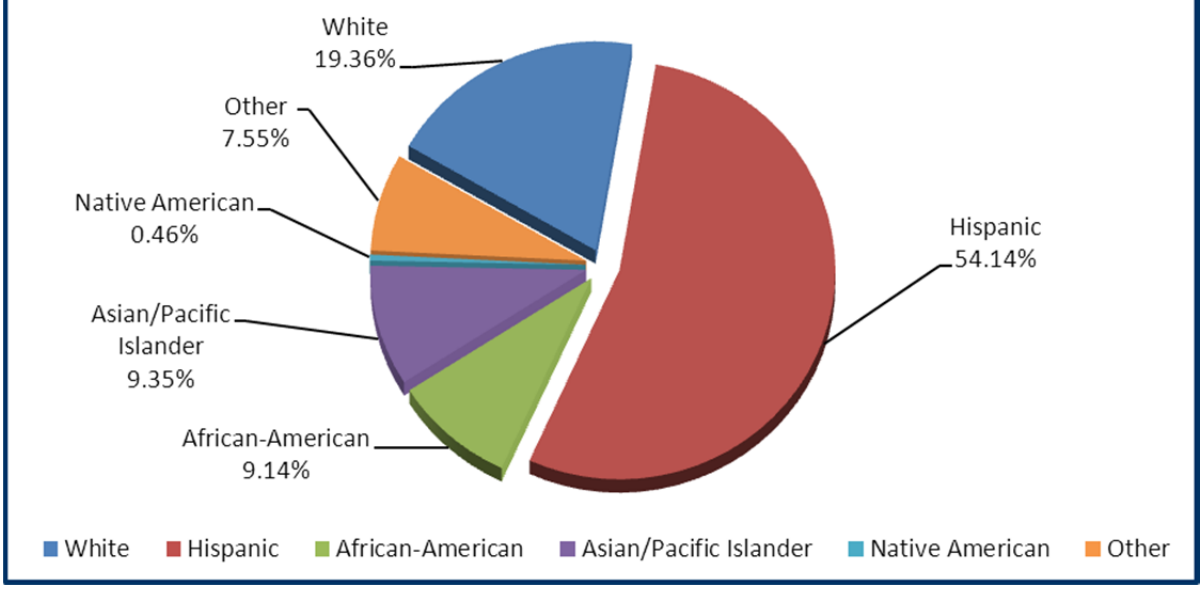


Figure 5b. Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity CY12

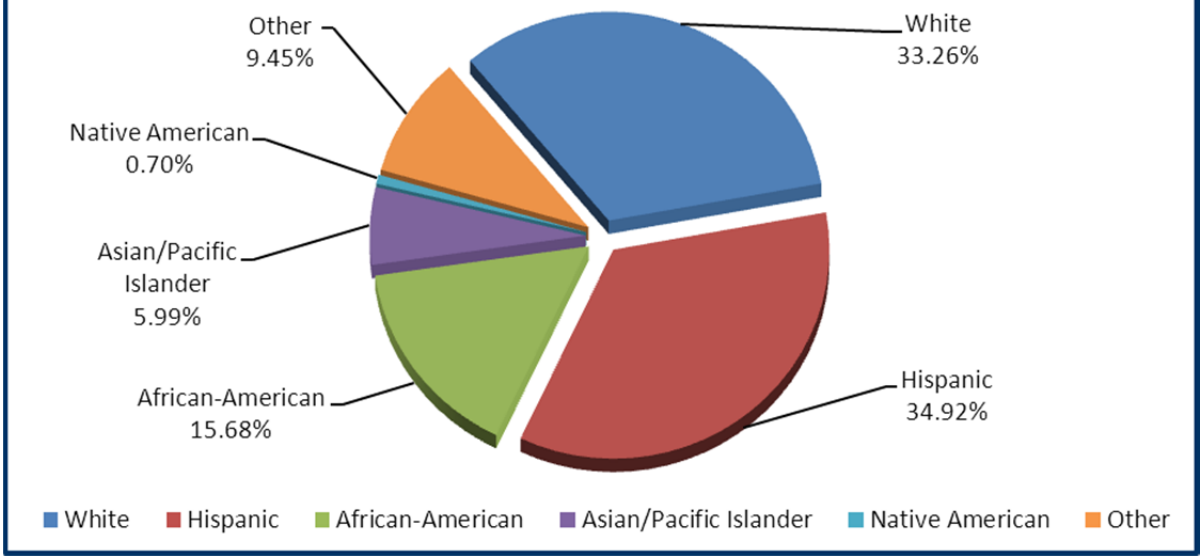


Figure 6a. San Diego Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY12

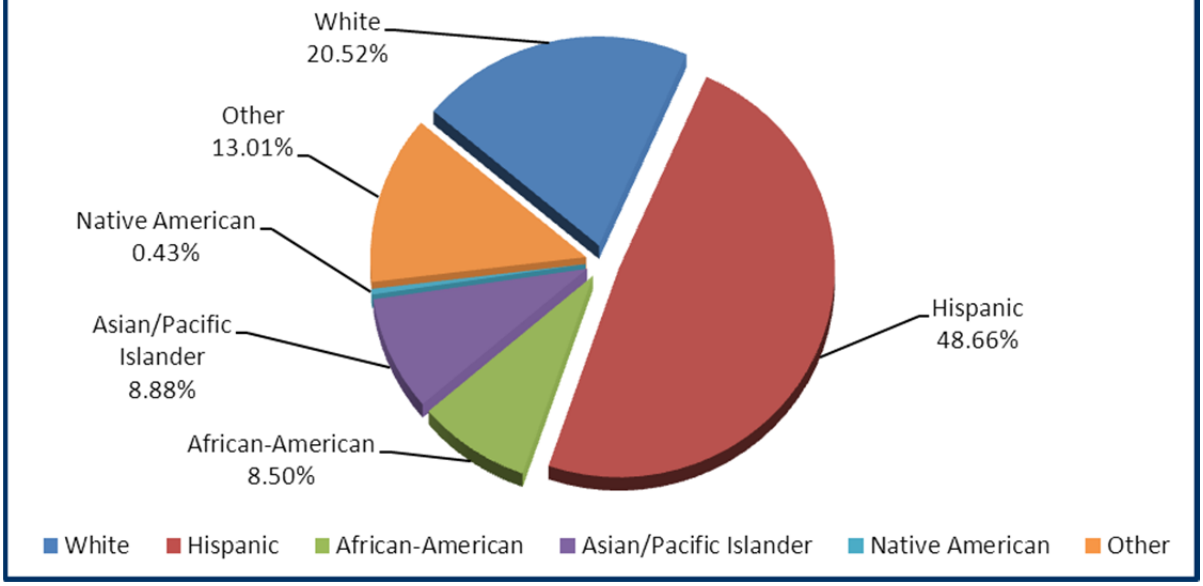
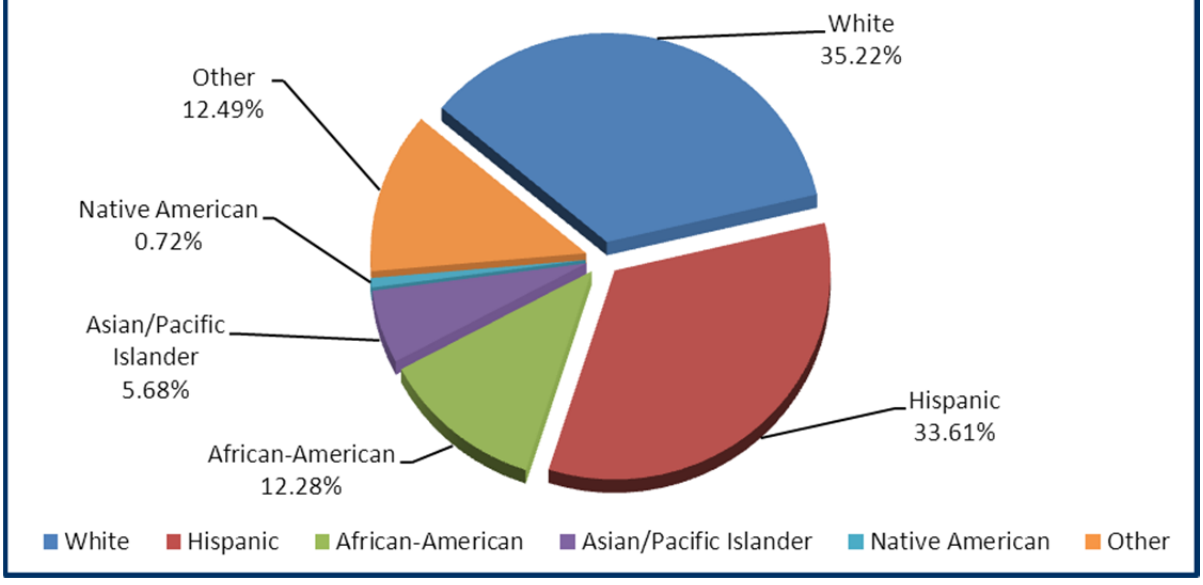


Figure 6b. San Diego Medi-Cal Beneficiaries Served, by Race/Ethnicity CY12



Penetration Rates and Approved Claim Dollars per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Rankings, where included, are based upon 56 MHPs, where number 1 indicates the highest rate or dollar figure and number 56 indicates the lowest rate or dollar figure.

Figure 7 displays key elements from the approved claims reports for the MHP, MHPs of similar size (large, medium, small, or small-rural), and the state.

Figure 7. CY12 Medi-Cal Approved Claims Data

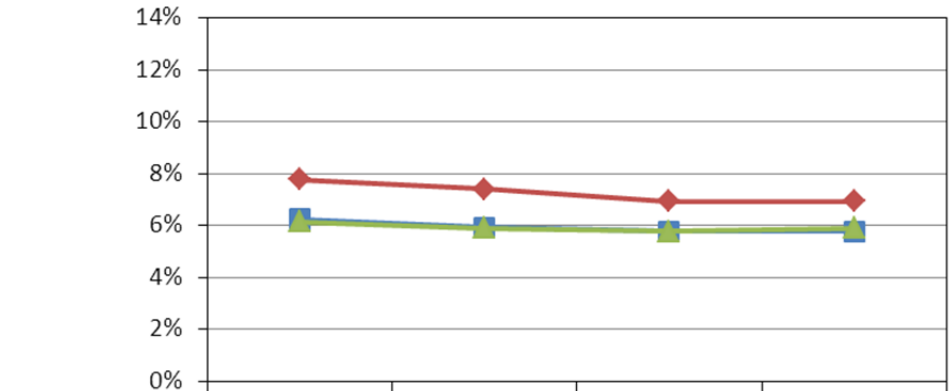
Element	San Diego	Rank	Large MHPs	Statewide
Total approved claims	$112,709,879	N/A	$1,011,905,446	$2,400,665,781
Average number of eligibles per month	459,365	N/A	3,750,774	7,956,900
Number of beneficiaries served	31,842	N/A	216,335	469,651
Penetration rate	6.93%	29	5.77%	5.90%
Approved claims per beneficiary Served	$3,540	42	$4,677	$5,112
Penetration rate – Foster care	60.38%	13	48.04%	53.34%
Approved claims per beneficiary served – Foster care	$7,472	21	$8,343	$8,485
Penetration rate – TAY	8.12%	31	6.86%	7.03%
Approved claims per beneficiary served – TAY	$4,640	35	$5,753	$6,331
Penetration rate – Hispanic	4.79%	17	3.63%	3.81%
Approved claims per beneficiary served – Hispanic	$3,422	37	$4,417	$4,913
Penetration rate – African-American	10.01%	29	9.65%	10.13%
Approved claims per beneficiary served – African-American	$4,490	32	$5,444	$5,318

Figure 7. CY12 Medi-Cal Approved Claims Data

Element	San Diego	Rank	Large MHPs	Statewide
Penetration rate – Asian/Pacific Islander	4.43%	22	3.63%	3.78%
Approved claims per beneficiary served – Asian/Pacific Islander	$2,467	39	$4,008	$4,089
Penetration rate – Other	6.66%	41	7.06%	7.39%
Approved claims per beneficiary served – Other	$3,168	46	$5,415	$5,650
Penetration rate – White	11.90%	15	10.20%	10.14%
Approved claims per beneficiary served – White	$3,592	43	$4,424	$5,245

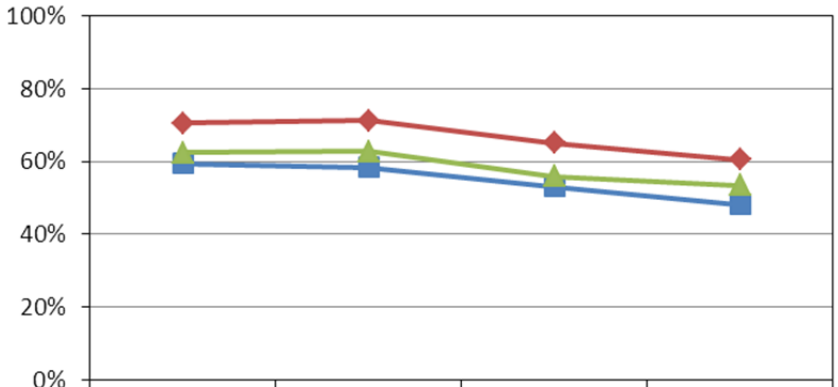
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.

Figure 8. Overall Penetration Rates CY09-CY12



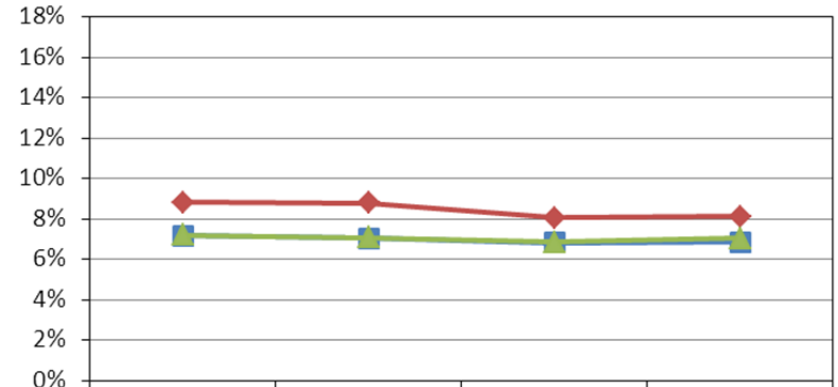
	CY09	CY10	CY11	CY12
San Diego	7.78%	7.40%	6.92%	6.93%
Large MHPs	6.25%	5.92%	5.76%	5.77%
Statewide	6.15%	5.89%	5.78%	5.90%

Figure 9. Foster Care Penetration Rates CY09-CY12



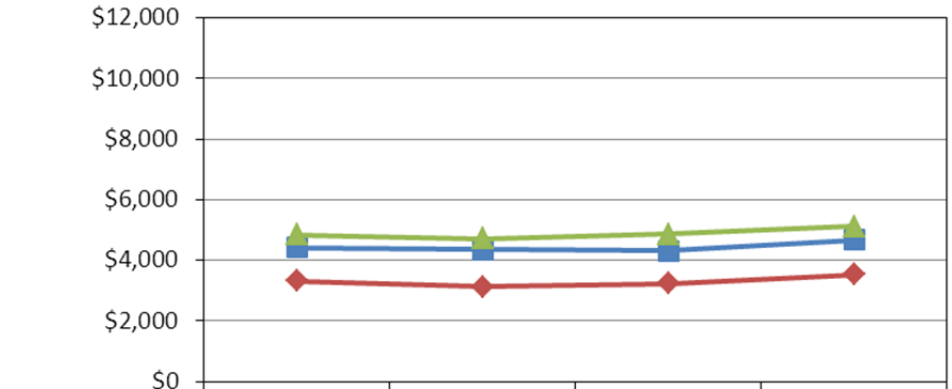
	CY09	CY10	CY11	CY12
San Diego	70.41%	71.12%	65.10%	60.38%
Large MHPs	59.43%	58.33%	52.99%	48.04%
Statewide	62.43%	62.67%	55.88%	53.34%

Figure 10. Transition Age Youth Penetration Rates CY09-CY12



	CY09	CY10	CY11	CY12
San Diego	8.82%	8.78%	8.06%	8.12%
Large MHPs	7.17%	7.05%	6.83%	6.86%
Statewide	7.21%	7.06%	6.86%	7.03%

Figure 11. Average Approved Claims per Beneficiary Served CY09-CY12



	CY09	CY10	CY11	CY12
San Diego	$3,311	$3,130	$3,238	$3,540
Large MHPs	$4,410	$4,351	$4,319	$4,677
Statewide	$4,841	$4,723	$4,872	$5,112

MEDI-CAL APPROVED CLAIMS HISTORY

The table below provides trend line information from the MHP's Medi-Cal eligibility and approved claims files from the last five fiscal years. The dollar figures are not adjusted for inflation.

Figure 12. San Diego Medi-Cal Eligibility and Claims Trend Line Analysis

Fiscal Year	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		$	Rank
FY11-12	456,494	31,136	6.82%	26	$100,752,876	$3,236	43
FY10-11	416,808	31,042	7.45%	29	$99,331,794	$3,200	44
FY09-10	424,038	30,809	7.27%	30	$95,228,053	$3,091	43
FY08-09	395,179	31,855	8.06%	28	$103,583,170	$3,252	38
FY07-08	373,433	31,422	8.41%	25	$95,486,775	$3,039	43

Review of Medi-Cal approved claims data, displayed in Figures 5 through 12 reflect the following issues that relate to quality and access to services:

- For CY12 the overall penetration rate (6.93%) was 20% higher than average for other large MHPs (5.77%) and 17% higher than the statewide average (5.90%).
- During CY12 the MHP's approved claims dollars per beneficiary served ($3,540) was 24% lower than the large-size MHP average ($4,677) and 31% lower than the statewide average ($5,112).
- The MHP's foster care penetration rate trended downward, from 71% to 60%, over the four year period from CY09-CY12. The statewide foster care penetration rate also trended downward during the same time period, from 63% to 53%. The MHP would benefit from investigating this downward trend and opportunities for reversing its direction
- For CY12, foster care approved claims dollars per beneficiary served ($7,472) was 10% lower than the large MHP average ($8,343) and 12% lower than the statewide average ($8,485).
- Approved claims dollars per Hispanic beneficiary served ($3,422) was 22% lower than large MHPs average ($4,417) and 30% lower than the statewide average ($4,913) – although within the MHP Hispanic claims are relatively comparable to the claims for White beneficiaries. Concurrently, the Hispanic penetration rate (4.79%) was 32% higher than the large MHP average (3.63%) and 26% higher than the statewide average (3.81%).
- The MHP has achieved timely claims submission during FY12-13. The denial rate (2.5%) during that FY was lower than the statewide rate of 4.1%. Detailed information regarding denials is available in Appendix D.

HIGH-COST BENEFICIARIES

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of beneficiaries within each MHP and the state for whom a disproportionately high dollar amount of services were claimed and approved. A stable pattern over the last five calendar years of data reviewed shows that statewide, roughly 2% of the beneficiaries served accounted for one-quarter of the Medi-Cal expenditures. The percentage of beneficiaries meeting the high cost definition has increased in each of the four years analyzed. For purposes of this analysis, CAEQRO defined "high cost beneficiaries" as those whose services met or exceeded $30,000 in the calendar year examined—this figure represents roughly three standard deviations from the average cost per beneficiary statewide.

Figure 13. High-Cost Beneficiaries (greater than $30,000 per beneficiary)						
	Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY12	12,479	469,651	2.66%	$50,451	$629,572,276	26.22%
San Diego CY12	534	31,842	1.68%	$45,015	$24,037,885	21.33%
San Diego CY11	457	31,526	1.45%	$44,036	$20,124,370	19.71%
San Diego CY10	448	30,328	1.48%	$44,920	$20,124,103	21.20%
San Diego CY09	465	31,764	1.46%	$43,267	$20,119,023	19.13%

CAEQRO also analyzed claims data for beneficiaries receiving $20,000 to $30,000 in services per year. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed. Statewide in CY12, 38.31% of the approved Medi-Cal claims funded 5.20% of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 34.67% of the approved Medi-Cal claims funded 3.62% of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- For CY12, HCBs represented 1.68% of all MHP beneficiaries served – an increase over CY11, but still 37% less than Statewide 2.66% for CY12.
- For CY12 total HCB dollars represent (21.33%) of Medi-Cal claims, compared to statewide (26.22%). The MHP percent of Medi-Cal dollars allocated to services to HCB has been less than the statewide percentages during the four year period displayed
- For CY12 the MHP funded the balance of its Medi-Cal services (96.38% for 30,690 beneficiaries) with 65.33% of its approved claims dollars. The average approved claims for those beneficiaries who received less than $20K in services was $2,399.

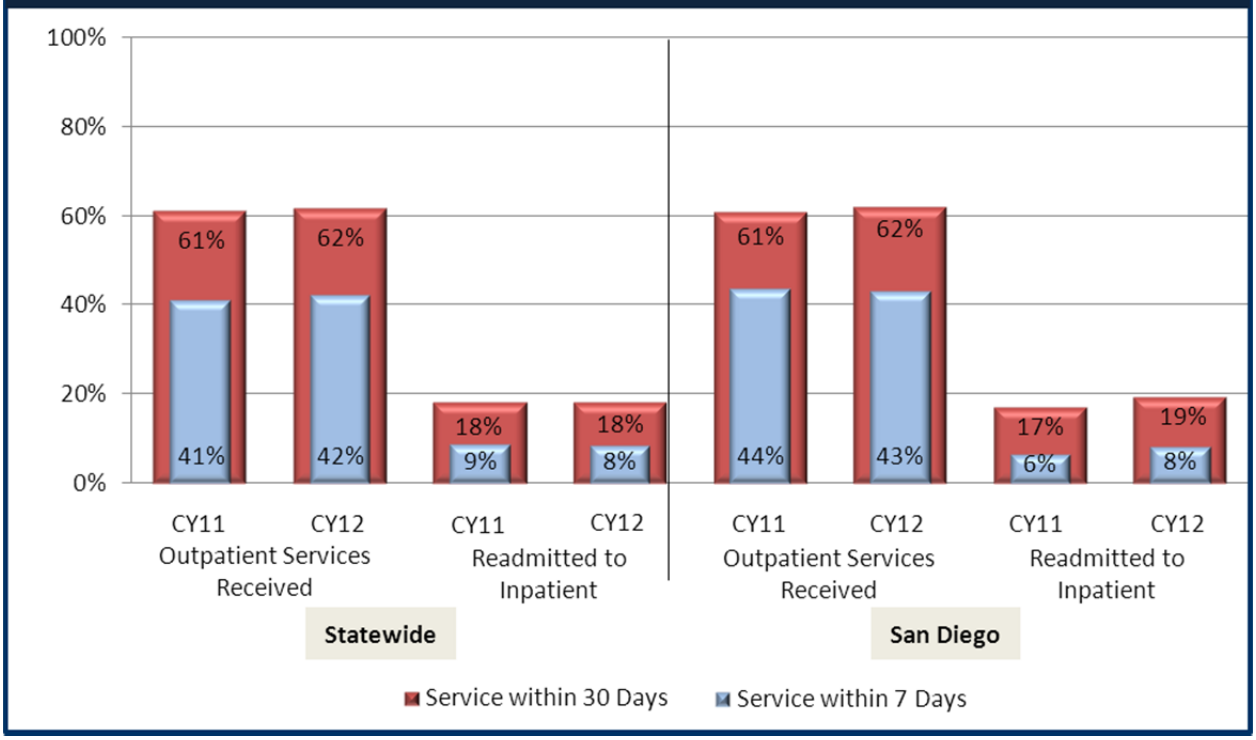
Timely Follow-up After Hospital Discharge

CAEQRO reviewed Medi-Cal approved claims to identify what percentage of beneficiaries statewide and within each MHP received a follow-up service after discharge from an inpatient setting -- within seven days and thirty days. Similarly, this analysis shows the percentage of beneficiaries who were re-hospitalized during those time frames. It should be noted that when Medi-Cal beneficiaries are admitted to inpatient facilities that do not bill Medi-Cal, those

inpatient episodes are not represented in the claims analysis. Also, this data includes only the first inpatient episode in that CY for a given beneficiary, from January through November.

Figure 14. Timely Follow-up: 7 and 30 days After Hospital Discharge

Percentage Receiving Outpatient Service or Readmitted MHP and Statewide, CY11 and CY12



Statewide in CY12, within seven days of discharge, 42% of beneficiaries received at least one non-inpatient service. Also within that time frame, 8% of beneficiaries were readmitted to an inpatient setting, a decrease over CY11 at 9%. Within a thirty day time frame, 62% of beneficiaries received a non-inpatient service after discharge in CY12, an increase from CY11 at 61%. The inpatient readmission rate held steady at 18%.

For the MHP, the follow-up and readmission rates reflect the following:

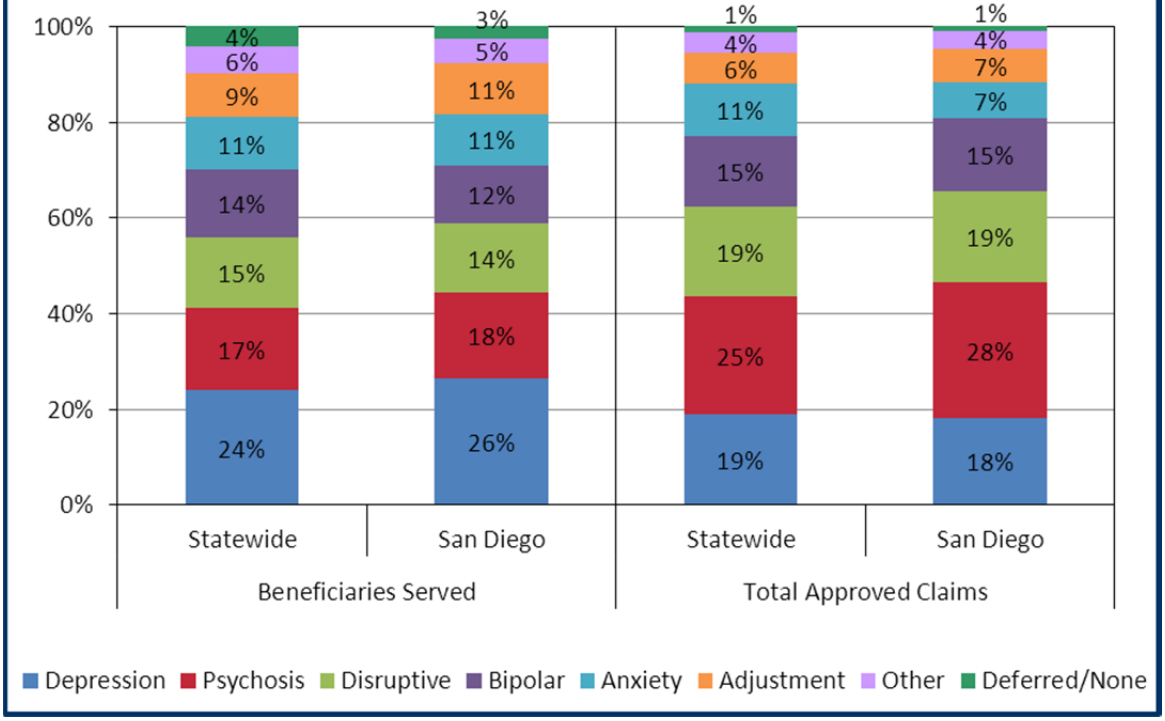
- During CY12, the MHP provided outpatient services to 43% of its beneficiaries within seven days of psychiatric hospital discharge, which was roughly equivalent to the statewide average performance of 42%. During this timeframe the MHP's inpatient readmission rate was the same as the statewide average (8%).
- During CY12, the MHP provided outpatient services to 62% of its beneficiaries within 30 days of psychiatric hospital discharge, which represents performance equivalent to the statewide average. During this

timeframe the MHPs readmission rate (19%) was slightly above the statewide average (18%), and slightly increased from the MHP CY11 rate of 17%.

DIAGNOSTIC CATEGORIES

CAEQRO reviewed approved claims to analyze the frequency of primary diagnoses throughout the state and each MHP. Similarly, this analysis examined the dispersal of approved claims by diagnostic category. For a complete list of the diagnoses within each diagnostic category, please refer to the CAEQRO Website at www.caeqro.com. The diagnoses reflect the primary diagnosis as reported on the Medi-Cal approved claims.

Figure 15. Diagnostic Categories
San Diego and Statewide CY12



Statewide in CY12, depressive disorders are most frequent at 24%. This is followed by psychotic disorders at 17%, disruptive disorders at 15%, and bipolar disorders at 14%. When examining approved claims, there are proportionately more funds expended on psychotic disorders (25%) and disruptive disorders (19%) and proportionately fewer funds expended on depressive disorders (19%) and adjustment disorders (6%). Statewide, 4% of diagnoses are deferred/none, though they represent only 1% of claims. Statewide there is little change in the diagnostic data compared to CY11 patterns.

For the MHP, diagnostic categories show the following:

- The MHP diagnostic and approved claims patterns closely mirror those seen statewide, with the exception of a somewhat lower percentage of approved claims going to services for beneficiaries with anxiety disorder diagnoses and slightly more claims to psychotic disorders.

❖PERFORMANCE MEASUREMENT❖

Each year CAEQRO is required to work in consultation with DHCS to identify a performance measurement (PM) which will apply to all MHPs – submitted to DHCS within the annual report due on August 31, 2014. These measures will be identified in consultation with DHCS for inclusion in this year's annual report.

❖CONSUMER AND FAMILY MEMBER FOCUS GROUPS❖

FOCUS GROUPS SPECIFIC TO THE MHP

CAEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CAEQRO requested focus groups as follows:

1. A diverse group of caregivers/guardians of foster care youth who receive MHP services.
2. A group of adult Medi-Cal beneficiaries who receive Spanish-language MHP services.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CAEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This focus group of caregivers/guardians of foster care youth who receive MHP services was held at 3255 Camino Del Rio South and included five participants. Participants expressed mixed

opinions of the services they were receiving, with some being satisfied and others not. Participants generally expressed that coordination of services between the MHP and CWS was difficult, with the primary difficulty being that CWS tended to refer to different mental health treatment providers than the MHP, which placed consumers in the position of needing to change therapists. Participants provided multiple instances in which their culture, heritage or religion were either misunderstood or not honored. In general the opinion was expressed that not enough services were available for those whose preferred language was not English.

Participants had limited contact with information sources from the MHP and only had this opportunity to participate a stakeholder process. Participants voiced uniformly high praise for services provided by parent partners. They also expressed that wellness and recovery were concepts that were present in the therapy relationship.

Recommendations arising from this group included:

- Increase the number of parent partners and general employment opportunities. Hire Spanish-speaking parent partners.
- Improve cultural competency training of providers, in particular residential providers.
- Improve coordination of services between CWS and the MHP.
- Provide concrete supports and tools—one example is to provide assistance in filling out required paperwork.
- Keep pamphlets and other educational/communication materials up to date.

Participants from the group provided the following demographic information:

Figure 16. Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumer Only	1
Consumer and Family Member	2
Family Member of Adult	
Family Member of Child	2
Family Member of Adult & Child	
Total Participants	5

Ages of Participants	
Under 18	
Young Adult (18-24)	
Adult (25-59)	5
Older Adult (60 and older)	

Preferred Languages	
English	

Race/Ethnicity	
African American	1
Caucasian	3
Hispanic	1

Gender	
Male	0
Female	5

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This focus group of adult consumers who receive services in Spanish was held at South East Mental Health Clinic at 3177 Ocean view Boulevard and included six participants. Participants reported receiving a variety of services including individual and group therapy, case management and medication management services. Consumers reported that psychiatry services were provided with the assistance of an interpreter. Participants reported receiving services for varying lengths of time; none reported difficulties related to timely access to clinical or psychiatric services. The majority of participants reported they were referred to the MHP by their primary care physician, or as a result of a psychiatric hospitalization.

All consumers reported receiving benefit from treatment and were complimentary about services and staff. Consumers reported that staff discuss recovery, hope, and quality of life issues with them. None of the consumers had been invited to or were aware of any opportunities to participate in MHP committees or planning activities. Likewise, none of the consumers were aware of information about mental health services from media such as television, radio, newspapers, or other written materials.

Consumers reported frustration that there were no Clubhouses that specifically focused on Spanish speakers. Several participants reported attempting to participate in Clubhouse programs but each eventually discontinued because of the lack of Spanish speaking staff.

Recommendations arising from this group include:

- More bilingual staff, including psychiatrists, peer partners and Clubhouse staff.
- Use various existing forms of Spanish-language media to provide information regarding mental health services.
- Provide group activities and outings.

Participants from the group provided the following demographic information:

Figure 17. Consumer/Family Member Focus Group 2

Number/Type of Participants	
Consumer Only	5
Consumer and Family Member	1
Family Member of Adult	
Family Member of Child	
Family Member of Adult & Child	
Total Participants	

Ages of Participants	
Under 18	
Young Adult (18-24)	
Adult (25-59)	5
Older Adult (60 and older)	1

Preferred Languages	
Spanish	6

Race/Ethnicity	
Hispanic	6

Gender	
Male	2
Female	4

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Spanish

❖PERFORMANCE IMPROVEMENT PROJECT VALIDATION❖

CLINICAL PIP

The MHP presented its study question for the clinical PIP as follows:

> "How can we decrease the rate of readmissions to psychiatric inpatient care following discharge? How can we improve the ability of recently discharged patients to live successfully outside of inpatient care? Will enhanced awareness and intervention will reduce psychiatric inpatient readmissions?"

Year PIP began: 2013

Status of PIP:

- ☐ Active and ongoing
- ☒ Completed (rated as active and ongoing for the review period)
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

In recognition of the financial costs and lack of successful consumer recovery after discharge, the MHP partnered with a multi-stakeholder workgroup to understand and mitigate the readmission rate within 30 days of discharge, which was 23% in FY 11-12. Causes/barriers were discussed, including that 44% of beneficiaries received no services within seven days of discharge. By way of developing relevant background information, MHP QI staff conducted literature searches and additionally identified locally relevant resources including accounting of the local hospitals and outpatient providers relevant to treatment of the target population. However, no specific data related to facility and provider discharge coordination of care efforts were provided to enable evaluation of local efforts.

The workgroup compiled strategies and protocols suggested by local mental health contract providers, and subsequently created a document of seven best practices to reduce the occurrence of hospital readmissions, "Best Practices – Commonalities through Multiple Programs That Help Clients with Connection to Services." The MHP also compiled a matrix of related literature and presentations, "Readmission Article Summary and Presentation Grid," which among other benefits, displays interventions and outcomes for six community providers that have identified successful strategies. Both of these products are valuable additions to the MHP's repertoire of prevention efforts, and any of the interventions could have been utilized to directly impact the rate at which MHP consumers are readmitted to hospitals.

Although this project highlights an important area for improvement, the MHP's approach hindered its ability to evaluate outcomes. The MHP did not consistently identify the study

population, nor the readmission rates it was attempting to impact. The primary PIP intervention—the compilation of best practices—was not implemented in a way that ensured that best practices were used or that the impact of best practices were measured. Further, the PIP does not contain baselines or indicators measuring the impact of the interventions on the "improved ability of discharged consumers to live successfully outside of the hospital."

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool.

Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 18. Clinical PIP Validation Review—Summary of Key Elements

Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable		X	
5	The indicators are designed to answer the study question		X	
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
7	The indicators each have accessible data that can be collected	X		
8	The study population is accurately and completely defined		X	
9	The data methodology outlines a defined and systematic process	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes		X	

Figure 18. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
11	The analyses and study results are conducted according to the data analyses plan in the study design	X		
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion	X		
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement	X		
Totals for 13 key criteria		**9**	**4**	

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report.

NON-CLINICAL PIP

The MHP presented its study question for the non-clinical PIP as follows:

> "Will targeted interventions at the Southeast MH Clinic, including trauma informed care training, staff development, change in practices and creating a warm and welcoming environment result in increased staff trauma informed care competences and consumer satisfaction?"

Year PIP began: 2013

Status of PIP:

- ☐ Active and ongoing
- ☒ Completed (rated as active and ongoing for the review period)
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

During FY12, the MHP found that 37.4% of adults/older adults receiving MH services had experienced trauma, and 29.4% reported childhood sexual abuse. After contracting with a consultant in January 2012, the MHP sponsored an assessment, consisting of interviews, surveys and site observations of county and provider staff to determine the current level of staff and provider trauma-informed competency. Baseline data indicated that of 885 individuals, 796

completed the surveys, 44% knew about Trauma-Informed Care (TIC) and 34% understood how to apply TIC. After attending a National Council for Community Behavioral Healthcare (NCBH) TIC conference in April 2013, the MHP obtained NCBH technical assistance and educational tools, and then began to focus on one MHP clinic which serves adults, older adults, children, youth and families to implement a series of best practices, including, but not limited to: staff training on recognition of their own and consumers' behaviors, histories of trauma, and need for a safe, welcoming environment for all; providing trauma focused evidence-based practices and supports; educating community providers to ensure that consumers are not re-traumatized; and creating quality assurance mechanisms that include consumer feed-back loops. The initial staff surveys identified that lack of education and the need to create a safe and secure environment were the priority issues to improving care for this population.

The MHP utilized existing consumer satisfaction surveys for adult and child consumers and caregivers from CY12 and CY13, and also administered an employee survey to clinical and support staff to assess trauma understanding; an additional consumer survey assessed perceptions and feelings of safety in the clinic environment. Indictors were then developed to track changes in outcomes for staff and consumers/families. Interventions began in April 2013 and were coordinated to respond to identified areas of concern in the three surveys. The interventions included bi-weekly staff/provider conferences to discuss the effectiveness of the TIC principles on consumers, environmental changes designed to improve welcoming and a sense of safety for consumers, and additional staff training.

Pre- implementation consumer satisfaction survey data were presented and they indicated that most adult and child satisfaction and treatment planning participation scores increased from CY12 to CY13, but caregivers' satisfaction decreased by 6.8 percentage points, from 81.8% to 75%. The significance of this finding is not specifically addressed. The MHP monitoring plan is to repeat all measurements in April 2014, in order to assess post-intervention outcomes.

While the PIP has formally concluded, if the MHP continues it as a QI project CAEQRO recommends the following:

- Investigate further the caregivers' most recent satisfaction responses before the April 2014 surveys are performed, as the number of respondents is historically very low, and the importance of caregiver satisfaction in relation to supporting youth's care cannot be overemphasized.
- Clarify how staff "competency" was and will be assessed. Is the MHP using staffs' own assessment of their theoretical knowledge as a proxy measure for clinical competency? If not, the study question needs to be revised.
- Investigate using the new consumer feedback tree at the clinic for quality improvement monitoring, as consumer satisfaction surveys have involved few people.
- Address the initial plan to extend TIC clinical interventions and monitoring throughout the MHP's system of care.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool.

Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 19. Non-Clinical PIP Validation Review—Summary of Key Elements

Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable	X		
5	The indicators are designed to answer the study question	X		
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
7	The indicators each have accessible data that can be collected		X	
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data		X	
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design		X	
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion	X		

Figure 19. Non-Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement			**X**
Totals for 13 key criteria		**9**	**3**	**1**

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report.

❖INFORMATION SYSTEMS REVIEW❖

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CAEQRO used the written response to standard questions posed in the California-specific ISCA Version 7.3.2, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

MHP Information Systems Overview

Key ISCA Information Provided by the MHP

The information below is self-reported by the MHP in the ISCA and/or the site review:

- Of the <u>total number of services provided</u>, what percentage is provided by:

Type of Provider	Distribution
County-operated/staffed clinics	8.96%
Contract providers	80.41%
Network providers	10.63%
	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

  ☐ Monthly ☒ More than 1x month ☐ Weekly ☐ More than 1x weekly

- Reported percent of MHP consumers served with co-occurring (substance abuse and mental health) diagnoses:

  32%

- Reported average monthly percent of missed appointments:

  3.9%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

  ☒ Yes ☐ No

The following should be noted with regard to the above information:

- While the overall co-occurring diagnoses rate is 32% the MHP reports the children and adolescent rate as 5% and the adult and older adult rate as 43%.
- The MHP calculates penetration rates every three years. Target population data is obtained from California Health Interview Survey prevalence estimates.

CURRENT OPERATIONS

- Hardware, software, and network management for Cerner and related systems is provided by Hewlett Packard. San Diego County Technology Office is responsible for overall contract management and supervision.
- Inpatient and network provider authorization and reporting continue to be provided through a contract with Optum Health, supported by 4 FTE technology positions. All positions are filled and there was no staff turnover during the past year.
- MHP staffing for Behavior Health Information System remains at 5.5 FTE positions. All positions are filled and there was no staff turnover during FY 12-13.

MAJOR CHANGES SINCE LAST YEAR

- Cerner Assessments version 3 was implemented.
- *Katie A.* requirements and functionality were implemented.
- AB109 documentation was enhanced.
- The MHP installed, tested, and implemented 12 Cerner software promotions (releases) during the current fiscal year.

PRIORITIES FOR THE COMING YEAR

- Resolution of Cerner performance issues and efficacy of Cerner Remote Hosting solution.
- Implementation of Cerner system upgrades to support:
  - Meaningful Use
  - DSM 5
  - ICD-10
- Implementation of Special Projects that monitors data integrity to ensure completeness and accuracy of data.
- Plan and implement disaster recovery and legacy data archiving.
- Test and implement signature pads that capture client signatures electronically.

OTHER SIGNIFICANT ISSUES

- As noted in prior CAEQRO reports, Cerner system response performance for users is problematic and cumulatively has a measureable impact on system wide staff productivity.
- Interoperability functionality between the Cerner system and the IS systems in use by contract providers continues to be unavailable, resulting in significant contract provider staff time spent on double data entry and transaction reconciliation.
- The MHP continues to rely on a hybrid medical record model as certain clinical and outcome data is housed outside the Cerner system, making it difficult for clinical staff to easily view client chart information.

The table below lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic

health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Figure 20. Current Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Operated By
Cerner	Practice Management, EHR, prescribing	Cerner	5	Hewlett Packard
Millennium	Hospital Inpatient	Cerner	3	Hewlett Packard
Eterby	Pharmacy	Cerner	3	Hewlett Packard
Chart Vault	Public Health Imaged Records	Hyland	1	Hewlett Packard
InSyst (legacy)	Practice Management	Echo Group	15	Optum
e-Cura (legacy)	Managed Care	InfoMC	14	Optum

PLANS FOR INFORMATION SYSTEMS CHANGE

The MHP has no plans to replace its current system. It continues to use a hybrid medical record model as health information exchange and interoperability functionality remain in the planning stages.

ELECTRONIC HEALTH RECORD STATUS

See the table below for a listing of EHR functionality currently in widespread use at the MHP.

Figure 21. Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Cerner	X			
Clinical Decision Support	Cerner & UCSD -HOM		X		
Document imaging				X	
Electronic signature - client	Cerner		X		
Electronic signature - provider	Cerner	X			
Laboratory results (eLab)				X	

Figure 21. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Outcomes	HSRC and DES		X		
Prescriptions (eRx)	Cerner	X			
Progress notes	Cerner	X			
Treatment plans	Cerner	X			
Contract Providers	Cerner	X			

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Client signature pads are being rolled-out during FY13-14 and are expected to be fully implemented by June 2014.
- Document imaging and electronic lab results remain in the planning stages. It is unclear whether this information is currently available in separate databases.
- Outcome data is currently being stored in separate databases.
- Contract providers are required to use the Cerner system for data entry. For those providers with their own EHR systems, the challenge of double data entry and reconciliation between the systems is both time-consuming and prone to errors.

❖SITE REVIEW PROCESS BARRIERS❖

The following conditions significantly affected CAEQRO's ability to prepare for and/or conduct a comprehensive review:

- There were no barriers affecting the preparation or the activities of this review.

❖CONCLUSIONS❖

During the FY13-14 annual review, CAEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CAEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access and timeliness of services and improving the quality of care.

STRENGTHS

1. The MHP, along with four Health Plans, have devoted significant resources to plan, design, and implement the Cal MediConnect Program. The program will serve dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system.
   [Access, Other: Healthcare integration]

2. The MHP is thoroughly examining the issues related to Laura's Law implementation while expanding voluntary assisted outpatient treatment resources.
   [Access]

3. The MHP has a strong Quality Improvement Unit and is collaborating more effectively with its academic research partners to utilize the data available to it.
   [Quality]

4. The MHP has committed to a path of introducing trauma informed care principles throughout the treatment system.
   [Quality, Outcomes]

OPPORTUNITIES FOR IMPROVEMENT

1. Tracking of key timeliness elements and unified timeliness goals continue to be a work in progress. Timeliness tracking by preferred language is not available.
   [Timeliness]

2. Spanish-speaking consumers and other limited English speaking consumers do not have equivalent access to resources such as clubhouses, parent partners, peer support specialists and relevant documentation from their medical record.
   [Access]

3. Instability of the Contracting Officer's Technical Representative (COR) functions due to staff turnover and integration of MHP and ADS COR staff has presented challenges for contractors in the areas of consistent communication and technical assistance.
[Quality, Other: Communications and training]

4. IS performance for Cerner users' remains a significant problem that impacts clinical staff productivity.
[Information Systems]

5. Contract providers continue to perform double data entry and transaction reconciliation which results in significant staff time being dedicated to manual processes. Likewise, patient admission and discharge data capture from hospitals continues to be a manual process.
[Information Systems, Quality]

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the review process, identified as an issue of access, timeliness, outcomes, quality, information systems, or others that apply:

1. Standardize timeliness goals across age demographics and regions. Continue to refine data collection methodologies to insure data accuracy as well as collection of data elements that capture differential access by racial/ethnic/linguistic groups.
[Timeliness, Quality]

2. Enhance access to consumer run clubhouses and parent partner/peer support specialists to populations in all the relevant threshold languages.
[Access]

3. Provide for consistent processes, messaging and training of Contracting Officer's Technical Representatives (COR) to enhance this valuable liaison role between the MHP and its contractors.
[Access]

4. Assign sufficient subject matter experts to complete the Cerner Remote Hosting solution as planned.
[Information Systems]

5. Investigate the feasibility of using interoperability functionality between Cerner system and contract providers with their IS systems and contracted hospitals to automate data exchange and eliminate double data entry and transaction reconciliation by providers. Similarly, automate hospital patient's admission and discharge data acquisition.
[Information Systems, Other: Quality]

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: Data Provided to the MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

A. Attachment—Review Agenda

<table>
<tr><th>Time</th><th colspan="3">Friday, March 14, 2014 Activities
Unless otherwise noted, all sessions will be held at 3255 Camino Del Rio S., San Diego, CA</th></tr>
<tr><td rowspan="3">9:00-11:00</td><td colspan="3"><u>Performance Management</u>
Access, Timeliness, Outcomes, and Quality</td></tr>
<tr><td colspan="2">• Introduction of participants
• Overview of review intent
• Significant MHP changes in past year
• Last Year's CAEQRO Recommendations</td><td>• Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality
• Examples of MHP reports used for to manage performance and decisions
• CAEQRO approved claims data</td></tr>
<tr><td colspan="3">Participants – Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions –including but not limited to:
• MHP Director, senior management team, and other managers/senior staff in: Fiscal, program, IS, medical, QI, research, patients' rights advocate
• Involved consumer and family member representatives</td></tr>
<tr><td>See cells for times</td><td>(11:00-12:00)
<u>Katie A. Implementation</u>

Include staff involved in the implementation and monitoring of Katie A. and at least one Child Welfare Partner
• Discussions of implementation readiness, strategies, and activities</td><td>(11:00- 11:30)
APS Staff – Working Lunch</td><td>(11:00-12:30)
<u>Healthcare Integration</u>

• Cal Mediconnect
• San Diego Paired Partner Model
• ICARE</td></tr>
<tr><td>See cells for times</td><td>(12:00-1:00)
APS Staff –Working Lunch</td><td>(11:30-1:00)
<u>Consumer/Family Member Focus Group</u>
A culturally diverse group of 8-10 parents and caregivers of foster care youth who are receiving MHP services.</td><td>(12:30-1:00)
APS Staff – Working Lunch</td></tr>
</table>

See cells for times	**(1:00-2:00)** **Outcomes/Timeliness** • MHP examples of data used to measure timeliness, functional outcomes and satisfaction • MHP's readiness for the upcoming EPSDT Performance Outcomes System as will be implemented by DHCS • Timely access for non-English speakers	**Travel** **(1:00-1:30)**	**(1:00-2:30)** **Contract Provider Group Interview** Group interview with clinical and business administrators from 6-8 identified contract providers
See cells for times	**(2:00-3:15)** **Performance Improvement Projects** • Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans • Participants should be those involved in the development and implementation including, but not necessarily limited to: PIP committee, MHP Director and other senior managers	**(1:30-3:00)** **Consumer/Family Member Focus Group** 8-10 **Adults who receive Spanish language services.** ***South East Mental Health Clinic*** ***3177 Ocean view Blvd., San Diego, CA 92113***	**(2:30-3:30)** **SD/MC Billing – Group Interview** • Short-Doyle Phase 2 Claim Process • Medicare/Medi-Cal claims • OHC/Medi-Cal claims • Void & Replace transactions • Denied claims • Katy A claim transactions • Contract Providers • New policies and procedures since last review

<table>
<tr><th>Time</th><th colspan="3">Activities (continued)</th></tr>
<tr><td>See cells for times</td><td>(3:30-4:30)
<u>Disparities in Service Access, Retention, Quality, or Outcomes</u>

• Review of MHP data or CAEQRO approved claims data to examine penetration rates and utilization patterns by age, ethnicity, or gender
• Review of Cultural Competency strategies to improve access/engagement and improve health equity
• Review of activities to address overall capacity</td><td>Travel (3:00-3:30)

(3:30-4:30)
<u>Consumer Employee Group Interview</u>

6-8 MHP employees who are consumers, such as Peer Advocates, Peer Support Specialist, or Consumer Liaisons.</td><td>(3:30-4:30)
<u>ISCA/ Use of Data</u>

• Review and discuss ISCA
• FY12-13 CAEQRO information technology recommendations
• Cerner software promotions
• Data used for to manage performance and decisions</td></tr>
<tr><td>4:30 – 4:45</td><td colspan="3">APS Staff Meeting</td></tr>
<tr><td>4:45 – 5:00</td><td colspan="3"><u>Final Questions Session</u>
MHP Director, QI Director, Senior leadership, and APS staff only

• Clarification discussion on any outstanding review elements
• MHP opportunity to provide additional evidence of performance
• CAEQRO Next steps after the review</td></tr>
</table>

B. Attachment—Review Participants

CAEQRO REVIEWERS

Dawn Kaiser, LCSW, CPHQ, Lead Reviewer
Bill Ullom, Information Systems Reviewer
Marilyn Hillerman, Consumer/Family Member Consultant
Rudy Lopez, MSW, MPA, Consulting Reviewer

Additional CAEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

SITES OF MHP REVIEW

CAEQRO staff visited the locations of the following county-operated and contract providers:

County provider sites

San Diego County Administrative Offices
3255 Camino Del Rio South
San Diego, CA 92108

South East Mental Health Clinic
3177 Oceanview Boulevard
San Diego, CA 92113

PARTICIPANTS REPRESENTING THE MHP

Andrew Sarkin, Director, Evaluation Services, University of California, San Diego
Alfie Gonzaga, Administrative Analyst
Alfredo Aguirre, Behavioral Health Director
Amanda Lance-Serton, Clinician
Amy Chadwick, Research Coordinator, Child Adolescent Services Researcher
Ana Briones -Espinoza, Business Analysis Manager, Optum Health
Andrea Carlin, Patient Advocate Supervisor, JFS Patient Advocacy
Angie DeVoss, Privacy Officer
Annlouise Conlaw, MIS Manager
Belle Nunley, Chief Financial Officer, Vista Hill
Bill Penfold, Senior IS Manager, Optum Health
Brian Hammond, Research Analyst
Carol Neidenberg, Program Manager, Legal and Society
Cathi Paladella, Assistant Deputy Director

Cecily Thornton-Stevens, Program Coordinator
Chona Penalba, Principal Accountant
Danyte Mockus-Valenzuela, Prevention and Planning Manager
Debbie Malcarne, Program Coordinator
Debbie Shriver, Associate Executive Director, North County Lifeline
Donna Ewing-Marko, Family Liaison, CYF
Edith Mohler, Administrative Analyst
Elizabeth Hernandez, Vice President, Neighborhood House Association
Emily Trask, Psychologist, University of California, San Diego
Erik Meserole, Peer Specialist, Hope Connections
George Scola, Health Plan Representative, Healthy San Diego
Greg Watson, Program Manager
Ian Rosengurten, Quality Improvement Specialist
Jamin Peek, Peer Liaison, Recovery Innovations
Jane Avila, Family Services Manager
Janice Hory, Peer Support Specialist, Hope Connections
Jean Fisher, Peer Liaison, Recovery Innovations
John Haegar, DBM
Judi Holder, Recovery Service Administrator, Recovery Innovations
Katie Astor, Assistant Deputy Director
Katrene Starnard, Peer Support Specialist, Recovery Innovations
Kim Peck, Vic President/CEO, Neighborhood House Association
Kris Summit, Administrative Analyst
Kristina Maxwell, Administrative Analyst
Kristopher Summit, Administrative Analyst
Laura Colligan, Program Manager
Laura Vleugels, Supervising Child/Adolescent Psychiatrist
Lauren Chin, Health Planning Program Specialist
Lauretta Monise, Chief, Children and Adult Mental Health Services
Lavonne Lucas, Medical Claims Manager
Lindsay Palmer, Administrative Analyst
Liz Miles, Administrative Analyst
Lizbeth Pesce, Peer Support Specialist, Recovery Innovations
Marc Gutbaum, Director, Vista Hill
Michael Krelsteson, Clinical/Medical Director,
Michael Bailey, Medical Director, Optum Health
Michelle Raby, Quality Improvement Specialist,
Michelle Galvan, Director of Business Operations, Optum Health
Mylene Fitzgerald, Associate Accountant
Nilsa Rubenstein, System Administrator, Optum Health
Patricia Madison, Administrative Analyst
Piedad Garcia, Assistant Deputy Director
Red Galura, Peer Support Specialist, Recovery Connections

Robert Bean, Chief Executive Officer, Vista Hill
Ruth Kenzelmann, Executive Director, Optum Health
Sandi Rosenstein, Peer Support Specialist, Hope Connections
Sasha Dahdouh, Research Analyst
Shelly Tregembo, Integrated Care Unit
Steve Jones, QM Program manager
Steven Tally, Director of Research, University of California, San Diego
Susan Bower, Director of Operations
Tabatha Lang, Chief, Quality Improvement Unit
Tamara Stark, Vice President, Exodus Recovery
Tamara Marthens, Dr., North County Lifeline
Tarsila Jaca, Administrative Analyst
Tesra Widmayer, Research Analyst
Tim Tormey, Quality Improvement Specialist
Virginia West, Program Coordinator
Wendy Maramba, Chief, Children Youth and Families
Yael Koenig, Chief

C. Attachment—Approved Claims Source Data

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

Source: Data in Figures 5 through 15 and Attachment D are derived from three statewide source files.

Short-Doyle/Medi-Cal approved and denied claims (SD/MC) from the Department of Health Care Services (DHCS)

Inpatient Consolidation approved claims (IPC) from DHCS

Monthly MEDS Extract Files (MMEF) from DHCS

Selection Criteria:

Medi-Cal beneficiaries for whom the MHP is the "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP

Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included

Process Date: The date DHCS processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2008 file with a DHCS process date of April 28, 2009 includes claims with service dates between January 1 and December 31, 2008 processed by DHCS through March 2009. Process dates are in parenthesis.

CY2012 includes SD/MC (November 2013), IPC (December 2013) and MMEF (March 2013) approved claims

CY2011 includes SD/MC (December 2012), IPC (March 2013) and MMEF (April 2012) approved claims

CY2010 includes SD/MC (June 2012), IPC (November 2012) and MMEF (April 2011)approved claims

CY2009 includes SD/MC (February 2011), IPC (October 2010) and MMEF (April 2010) approved claims

FY11-12 includes SD/MC (December 2012), IPC (March 2013) and MMEF (October 2012) approved claims

FY10-11 includes SD/MC (June 2012), IPC (March 2013) and MMEF (October 2011) approved claims

FY09-10 includes SD/MC (February 2011), IPC (October 2010) and MMEF (October 2012) approved claims

FY08-09 includes SD/MC (December 2009), IPC (December 2009) and MMEF (October 2009) approved claims

FY07-08 includes SD/MC (April 2009), IPC (April 2009) and MMEF (January 2009) approved claims

FY12-13 denials include SD/MC claims (not IPC claims) with process date November 2013

Most recent MMEF includes Medi-Cal eligibility for April (CY) or October (FY) and 15 prior months

Service Activity: Defined by Service Modes and Functions

Inpatient Services	Local Hospital Inpatient, Hospital Administrative Days, Psychiatric Health Facility, and Professional Inpatient Visit
Residential Services	Adult Crisis Residential and Adult Residential
Crisis Stabilization	Crisis Stabilization
Day Treatment	Day Intensive Treatment and Day Rehabilitative
Case Management	Case Management/Brokerage
Mental Health Services	Mental Health Services
Medication Support	Medication Support
Crisis Intervention	Crisis Intervention
TBS	Therapeutic Behavioral Services
Outpatient Services (applicable only to inpatient follow-up services)	Residential, Crisis Stabilization, Day Treatment, Case Management, Mental Health, Medication Support, Crisis Intervention, TBS Services

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

Data Definitions: Selected elements displayed in many figures within this report are defined below.	
Penetration rate	The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
Approved claims per beneficiary served per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year
Age Group	A beneficiary's age group is determined by beneficiary's age on July 1 of the reporting calendar year.
Eligibility Categories	Medi-Cal aid codes used for approved claims reporting by eligibility category. **Bolded/Blue Aid Codes** indicate EPSDT status with enhanced FFP funding for beneficiaries whose age is less than 21 years on date of service.
Claims Codes	
Disabled	**2H, 36, 60, 63, 64, 66, 67, 6C, 6E, 6G, 6H, 6N, 6P,** 6R, 6U, **6V, 6W, 6X, 6Y,** C3, C4, C7, C8, D4, D5, D6, D7
Foster Care	**40, 42, 43, 46, 49, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W, 5K**
Other Child	Beneficiary age is less than 18 AND has one of the following aid codes: **0A, 0M, 0N, 0P, 0W, 01,** 1U, **02, 03, 04, 06, 07, 08, 2A, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G,** 3F, **3H, 3L, 3M, 3N, 3P, 3R,** 3T, **3U,** 3V, **3W,** 44, **45, 47,** 48, **4A, 4E, 4M, 4P, 4R, 54,** 55, 58, **59, 5C, 5D, 5E,** 5F, 5J, 5R, 5T, 5W, 69, **6A,** 6J, 6K, 6M, **72,** 74, 76, **7A,** 7C, **7J,** 7K, **7X, 82, 83,** 86, 87, **8E, 8G,** 8N, **8P, 8R,** 8T, **8U, 8V, 8W, 8X,** C1, C2, C5, C6, C9, D1, E1, **E2,** E4, **E5, E7,** G0, G1, G2, G5, G6, G7, G8, G9, **H0, H1, H2, H3, H4, H5, H6, H7, H8, H9,** J1, J2, J3, J4, J5, J6, J7, J8, K1, M0, M3, M4, **M5,** M6, M7, M8, P0, **P1,** P2, P3, P4, **P5,** P6, **P7,** P8, **P9,** T0, **T1, T2, T3, T4, T5,** T6, T7, T8, T9.
Family Adult	Beneficiary age is greater than or equal to 18 AND has one of the following aid codes: 0A, 0W, 0M, 0N, 0P, 01, 1U, 02, 03, 04, 06, 07, 08, 2A, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3T, 3U, 3V, 3W, 44, 45, 47, 48, 4A, 4E, 4M, 4P, 4R, 54, 55, 58, 59, 5C, 5D, 5E, 5F, 5J, 5R, 5T, 5W, 69, 6A, 6J, 6K, 6M, 72, 74, 76, 7A, 7C, 7J, 7K, 7X, 82, 83, 8E, 8G, 8N, 8P, 8R, 8T, 8U, 8V, 8W, 8X, C1, C2, C5, C6, C9, D1, E1, E2, E4, E5, E7, G2, G6, G8, G9, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, J3, J4, J6, J8, M0, M4, M5, M6, M8, P1, P4, P5, P6, P7, P8, P9, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9.
Other Adult	Beneficiary age is greater than 19 AND has one of the following SD/MC program aid codes: 0U, 0V, 1E, 1H, 1X, 1Y, 10, 13, 14, 16, 17, 6J, 80, 86, 87, D2, D3, D8, D9, E1, L1, M1, M2, N0, N5, N6, N7, N8, N9, P2, P3.
EPSDT Eligible Aid Codes	Beneficiary age is less than 21 AND has one of the following aid codes: **0A, 0M, 0N, 0P, 0W, 01, 02, 2A, 2E, 2H, 03, 04, 06, 07, 08, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 36, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 43, 45, 46, 47, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4P, 4R, 4S, 4T, 4W, 54, 59, 5C, 5D, 5E, 5K, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6V, 6W, 6X, 6Y, 72, 7A, 7J, 7X, 82, 83, 8E, 8G, 8P, 8R, 8U, 8V, 8W, 8X, E2, E5, E7, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, M5, P1, P5, P7, P9, T1, T2, T3, T4, T5.**
Aid codes excluded for claims reporting purposes - as they are not SD/MC funded aid codes	0, 00, 0R, 0T, 09, 18, 28, 2G, 31, 3J, 3K, 3X, 3Y, 41, 43, 4C, 4K, 50, 51, 53, 56, 5X, 5Y, 61, 62, 65, 68, 6D, 6F, 6T, 78, 7M, 7N, 7P, 7R, 81, 84, 85, 88, 89, 8A, 8F, 8H, 8Y, 9A, 9C, 9E, 9F, 9G. 9H, 9J, 9K, 9M, 9N, 9R, 9S, 9X, FX, IE, R1, RR.

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

MEDS Race/Ethnicity Codes			
1 = White	2 = Hispanic	3 = Black	4 = Asian/Pacific Islander
5 = Alaska native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other

Race/Ethnicity Group	MEDS Code
White	1
Hispanic	2
African-American	3
Asian/Pacific Islander	4 & 7 + A thru V
Native American	5
Other	8 & 9 + Z

01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera
21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter/Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo

Counties by DHCS Regions	
Bay Area	01,07,21,27,28,35,38,41,43,44,48,49
Central	02,03,05,09,10,16,20,22,24,26,31,34,39,50,51,54,55,57
Los Angeles	19
Southern	13,15,30,33,36,37,40,42,56
Superior	04,06,08,11,12,14,17,18,23,25,29,32,45,47,52,53

Counties by DHCS County Sizes	
Large	01,07,10,15,30,33,34,36,37,38,43,56
Medium	04,21,24,27,31,39,40,41,42,44,48,49,50,54,57
Small	09,12,13,16,17,20,23,28,29,35,45,51,52,55
Small-Rural	02,03,05,06,08,11,14,18,22,25,26,32,47,53
Very Large	19

APS Healthcare

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, February 2014 Source: Medi-Cal Aid Code Chart Master dated – October 28,2013

Diagnosis Category	Diagnosis Codes Found in CY12 SD/MC II Approved Claims Files
Depressive Disorders	296.20 - 296.26, 296.83, 296.30 – 296.36, 300.4, 311.
Psychotic Disorders	293.81, 295.10 – 295.90, 297.1, 297.3, 298.8.
Disruptive Disorders	312.81 - 312.89, 312.9, 313.81, 314.00, 314.01, 314.9.
Bipolar Disorders	296.01 – 296.06, 296.40 - 296.76, 296.80, 296.89, 301.13.
Anxiety Disorders	293.84, 300.00 – 300.03, 300.21 - 300.23, 300.29, 308.3, 309.81.
Adjustment Disorders	309.0 – 309.9.
Other Disorders	Substance-Related disorders: 291.0 - 291.2, 291.3, 291.5, 291.89, 291.9, 292.0, 292.11, 292.12, 292.81 - 292.84, 292.89, 292.9, 303.00, 303.90, 304.00 - 304.90, 305.00, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90. Childhood disorders: 315.00, 315.1-315.4, 317, 318.0 – 318.2, 319, 299.00, 299.10, 299.80, 307.0, 307.52, 307.59, 307.20 - 307.23, 307.6, 307.7, 307.9, 313.82, 313.23, 313.89, 787.6. Amnesic/Cognitive /Movement disorders: 294.0, 290.10-290.13, 290.20-290.21, 290.40 - 290.43, 293.0, 294.8 - 294.11, 300.6, 300.9, 307.3, 307.89, 333.1, 333.82, 333.90, 780.09, 995.81. Personality disorders: 301.0, 301.22, 301.4, 301.50, 301.6, 301.7, 301.81 - 301.83, 301.9. Sexual/Impulse-Control disorders: 302.72, 302.75, 302.2, 302.3, 302.4, 302.6, 302.81, 302.84, 302.85, 302.89, 302.9, 312.31- 312.34, 312.39, 607.84. Sleep/Eating/Body/Other: 293.9, 300.7300.11, 300.18, 300.81, 300.82, 300.16, 300.19, 306.51, 307.42, 307.1, 307.45 - 307.47, 347, 307.50, 307.51, 307.80, 310.1, 310.20, 780.52, 780.54, 780.59. Relational Problems/Clinical Conditions: V15.81, V61.10, V61.12, V61.20, V61.21, V61.8, V61.9, V62.2, V62.3, V62.4, V62.81, V62.82, V62.89, V65.2, V71.01, V71.02. Other Conditions – 316, 332.1
Deferred and No Diagnoses	799.9, V71.09.

D. Attachment— Medi-Cal Approved Claims Worksheets and Additional Tables

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 12

Date Prepared:	01/24/2014, Version 1.3
Prepared by:	Rachel Phillips, APS Healthcare / CAEQRO
Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/22/2013, 12/26/2013, and 03/27/2013 - Note (3)

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	459,365	31,842	$112,709,879	6.93%	$3,540	5.77%	$4,677	5.90%	$5,112
AGE GROUP									
0-5	88,528	1,780	$3,837,326	2.01%	$2,156	1.56%	$4,361	1.88%	$4,150
6-17	129,869	11,736	$54,244,929	9.04%	$4,622	7.29%	$5,719	7.80%	$6,472
18-59	167,049	15,729	$48,585,584	9.42%	$3,089	7.68%	$4,181	7.37%	$4,455
60+	73,921	2,597	$6,042,040	3.51%	$2,327	3.33%	$3,398	3.45%	$3,529
GENDER									
Female	260,532	16,113	$49,818,382	6.18%	$3,092	5.25%	$4,154	5.31%	$4,593
Male	198,833	15,729	$62,891,497	7.91%	$3,998	6.44%	$5,224	6.66%	$5,640
RACE/ETHNICITY									
White	94,279	11,216	$40,288,781	11.90%	$3,592	10.20%	$4,424	10.14%	$5,245
Hispanic	223,519	10,702	$36,619,357	4.79%	$3,422	3.63%	$4,417	3.81%	$4,913
African-American	39,037	3,909	$17,551,549	10.01%	$4,490	9.65%	$5,444	10.13%	$5,318
Asian/Pacific Islander	40,804	1,809	$4,462,915	4.43%	$2,467	3.63%	$4,008	3.78%	$4,089

	SAN DIEGO						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	1,972	229	$1,187,736	11.61%	$5,187		10.19%	$5,469		9.09%	$5,548
Other	59,758	3,977	$12,599,541	6.66%	$3,168		7.06%	$5,415		7.39%	$5,650
ELIGIBILITY CATEGORIES											
Disabled	78,084	14,002	$51,366,202	17.93%	$3,668		17.26%	$4,904		17.60%	$5,109
Foster Care	3,400	2,053	$15,339,808	60.38%	$7,472		48.04%	$8,343		53.34%	$8,485
Other Child	207,353	11,059	$37,250,193	5.33%	$3,368		4.21%	$4,388		4.65%	$4,950
Family Adult	94,925	4,868	$6,871,718	5.13%	$1,412		4.19%	$2,229		3.96%	$2,604
Other Adult	76,375	848	$1,881,958	1.11%	$2,219		1.01%	$3,545		1.00%	$3,535
SERVICE CATEGORIES											
Inpatient Services	459,365	2,829	$17,358,957	0.62%	$6,136		0.44%	$7,835		0.45%	$7,723
Residential Services	459,365	808	$3,320,215	0.18%	$4,109		0.08%	$7,525		0.06%	$7,775
Crisis Stabilization	459,365	1,179	$2,241,146	0.26%	$1,901		0.49%	$2,176		0.38%	$1,948
Day Treatment	459,365	1,285	$12,953,354	0.28%	$10,080		0.10%	$11,381		0.06%	$12,207
Case Management	459,365	8,593	$6,646,294	1.87%	$773		2.19%	$1,041		2.41%	$899
Mental Health Serv.	459,365	25,167	$47,296,002	5.48%	$1,879		4.52%	$2,996		4.82%	$3,478
Medication Support	459,365	16,188	$16,063,578	3.52%	$992		2.97%	$1,153		2.94%	$1,332
Crisis Intervention	459,365	1,545	$978,499	0.34%	$633		0.47%	$814		0.59%	$1,046
TBS	459,365	691	$5,851,836	0.15%	$8,469		0.11%	$10,644		0.10%	$12,091

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 577,323

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY12

	SAN DIEGO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	2,539	7.97	7.97	9.38	9.38	4.90	18.87
2 services	2,254	7.08	15.05	6.29	15.67	0.00	12.84
3 services	2,399	7.53	22.59	5.38	21.06	2.94	11.11
4 services	1,895	5.95	28.54	4.93	25.98	1.93	9.40
5 - 15 services	12,047	37.83	66.37	32.38	58.36	21.24	40.93
> 15 services	10,708	33.63	100.00	41.64	100.00	23.68	60.46

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year CY12

Foster Care

Date Prepared:	01/24/2014, Version 1.2
Prepared by:	Rachel Phillips, APS Healthcare / CAEQRO
Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/22/2013, 12/26/2013, and 03/27/2013 - Note (3)

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	3,400	2,053	$15,339,808	60.38%	$7,472	48.04%	$8,343	53.34%	$8,485
AGE GROUP									
0-5	1,146	553	$1,279,834	48.25%	$2,314	28.63%	$4,165	36.10%	$3,952
6+	2,255	1,500	$14,059,974	66.52%	$9,373	55.72%	$9,193	60.04%	$9,544
GENDER									
Female	1,662	991	$7,090,280	59.63%	$7,155	47.16%	$8,077	52.55%	$8,240
Male	1,739	1,062	$8,249,528	61.07%	$7,768	48.86%	$8,584	54.09%	$8,707
RACE/ETHNICITY									
White	1,006	646	$4,469,551	64.21%	$6,919	51.72%	$7,476	56.34%	$9,153
Hispanic	1,339	799	$5,641,176	59.67%	$7,060	45.66%	$7,690	51.29%	$6,995
African-American	765	453	$4,243,573	59.22%	$9,368	48.89%	$9,687	50.68%	$8,767
Asian/Pacific Islander	124	79	$457,600	63.71%	$5,792	50.99%	$8,868	53.73%	$8,121

	SAN DIEGO						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	78	39	$360,391	50.00%	$9,241		50.28%	$6,375		45.17%	$6,902
Other	90	37	$167,518	41.11%	$4,528		39.00%	$12,941		41.80%	$10,199
SERVICE CATEGORIES											
Inpatient Services	3,400	87	$451,537	2.56%	$5,190		1.72%	$6,922		2.09%	$7,484
Residential Services	3,400	1	$456	0.03%	$456		0.01%	$6,987		0.01%	$9,294
Crisis Stabilization	3,400	45	$62,922	1.32%	$1,398		1.34%	$1,580		1.16%	$1,547
Day Treatment	3,400	553	$6,730,435	16.26%	$12,171		3.07%	$13,670		2.31%	$13,509
Case Management	3,400	382	$114,878	11.24%	$301		19.66%	$1,530		23.26%	$1,128
Mental Health Serv.	3,400	1,736	$5,720,034	51.06%	$3,295		44.78%	$5,545		50.68%	$5,890
Medication Support	3,400	689	$935,084	20.26%	$1,357		14.99%	$1,414		16.68%	$1,710
Crisis Intervention	3,400	90	$86,128	2.65%	$957		2.61%	$1,072		3.40%	$1,587
TBS	3,400	128	$1,193,653	3.76%	$9,325		3.49%	$10,248		3.57%	$11,250

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 4,997

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY12

Foster Care

	SAN DIEGO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	65	3.17	3.17	6.08	6.08	0.00	50.00
2 services	114	5.55	8.72	4.91	11.00	0.00	17.65
3 services	248	12.08	20.80	4.25	15.24	0.00	19.35
4 services	84	4.09	24.89	3.34	18.58	0.00	33.33
5 - 15 services	435	21.19	46.08	25.11	43.69	0.00	100.00
> 15 services	1,107	53.92	100.00	56.31	100.00	0.00	77.78

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 12

Transition Age Youth (Age 16-25)

Date Prepared:	01/24/2014, Version 1.1
Prepared by:	Rachel Phillips, APS Healthcare / CAEQRO
Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/22/2013, 12/26/2013, and 03/27/2013 - Note (3)

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	65,837	5,344	$24,797,102	8.12%	$4,640	6.86%	$5,753	7.03%	$6,331
AGE GROUP									
16-17	20,525	2,398	$13,258,793	11.68%	$5,529	9.37%	$6,651	9.89%	$7,412
18-21	29,498	2,038	$8,383,530	6.91%	$4,114	6.25%	$5,351	6.35%	$5,747
22-25	15,815	908	$3,154,778	5.74%	$3,474	4.95%	$4,637	4.82%	$5,039
GENDER									
Female	39,052	2,626	$11,431,718	6.72%	$4,353	5.79%	$5,441	5.94%	$6,055
Male	26,785	2,718	$13,365,383	10.15%	$4,917	8.41%	$6,065	8.58%	$6,603
RACE/ETHNICITY									
White	11,663	1,581	$7,266,087	13.56%	$4,596	10.90%	$5,309	11.62%	$6,681
Hispanic	35,909	2,261	$9,598,964	6.30%	$4,245	4.86%	$5,130	5.09%	$5,777
African-American	6,948	768	$4,549,000	11.05%	$5,923	10.80%	$6,657	10.78%	$6,545
Asian/Pacfic Islander	4,412	181	$871,887	4.10%	$4,817	3.36%	$6,527	3.50%	$6,494

	SAN DIEGO						LARGE			STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year		Penetration Rate	Approved Claims per Beneficiary Served per Year
Native American	337	36	$295,020	10.68%	$8,195		10.05%	$6,961		9.47%	$6,893
Other	6,570	517	$2,216,145	7.87%	$4,287		10.44%	$7,213		10.08%	$7,408
ELIGIBILITY CATEGORIES											
Disabled	6,681	1,379	$6,946,297	20.64%	$5,037		19.73%	$6,644		20.83%	$7,046
Foster Care	767	540	$5,607,015	70.40%	$10,383		59.17%	$9,663		65.95%	$9,649
Other Child	18,923	1,916	$7,685,812	10.13%	$4,011		7.74%	$5,007		8.30%	$5,665
Family Adult	32,842	1,473	$3,763,242	4.49%	$2,555		4.07%	$3,319		4.22%	$3,791
Other Adult	6,859	296	$794,736	4.32%	$2,685		3.63%	$4,321		3.29%	$4,587
SERVICE CATEGORIES											
Inpatient Services	65,837	687	$3,720,396	1.04%	$5,415		0.82%	$7,186		0.83%	$6,922
Residential Services	65,837	101	$348,362	0.15%	$3,449		0.07%	$6,878		0.06%	$8,030
Crisis Stabilization	65,837	280	$407,324	0.43%	$1,455		0.78%	$1,727		0.62%	$1,661
Day Treatment	65,837	537	$6,336,381	0.82%	$11,800		0.21%	$12,669		0.16%	$13,319
Case Management	65,837	1,427	$1,143,007	2.17%	$801		2.73%	$1,207		2.99%	$1,001
Mental Health Serv.	65,837	4,206	$9,347,292	6.39%	$2,222		5.61%	$3,536		5.93%	$4,260
Medication Support	65,837	2,557	$2,401,812	3.88%	$939		3.16%	$1,147		3.14%	$1,351
Crisis Intervention	65,837	412	$302,136	0.63%	$733		0.77%	$862		0.97%	$1,090
TBS	65,837	96	$790,392	0.15%	$8,233		0.16%	$10,245		0.16%	$10,312

Footnotes:

1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 95,271

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY12

Transition Age Youth (Age 16-25)

	SAN DIEGO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	442	8.27	8.27	9.96	9.96	0.00	21.54
2 services	377	7.05	15.33	6.31	16.27	0.00	18.00
3 services	370	6.92	22.25	5.29	21.56	0.00	21.43
4 services	274	5.13	27.38	4.59	26.15	0.00	33.33
5 - 15 services	1,802	33.72	61.10	28.93	55.08	15.91	40.98
> 15 services	2,079	38.90	100.00	44.92	100.00	21.05	65.91

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/26/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

SD/MC Claims Processing Summary

The following table provides a summary of the MHP's SD/MC claims processed for services claimed during FY12-13. The data presents claims processed by the State as of November 2013 and may not yet include all original or replacement claim transactions for FY12-13. To meet timely processing rules, MHPs have 12 months from the service month to submit original claim transactions and 15 months from the service month to submit replacement claim transactions.

Figure D-1. Monthly Summary of SD/MC Claims – FY12-13
Claims Processed as of November 2013

Service Month	Gross Dollars Billed by MHP	Denied Dollars	Denial Rate	Number Denied Claims	Claims Adjudicated	Claim Adjustments	Approved Dollars	Percent Approved	Number Approved Claims	Replaced Claim Dollars	Number Replaced Claims
JUL12	$9,469,075	$748,360	7.9%	1,031	$8,720,715	$156,944	$8,563,770	98.2%	49,657	$0	0
AUG12	$9,860,670	$620,051	6.3%	888	$9,240,619	$180,035	$9,060,583	98.1%	52,669	$0	0
SEP12	$8,639,896	$220,322	2.6%	603	$8,419,574	$150,548	$8,269,025	98.2%	49,385	$0	0
OCT12	$10,608,893	$223,184	2.1%	814	$10,385,709	$195,487	$10,190,222	98.1%	59,533	$0	0
NOV12	$9,280,426	$157,882	1.7%	788	$9,122,544	$178,112	$8,944,432	98.0%	51,182	$0	0
DEC12	$8,351,758	$169,351	2.0%	691	$8,182,407	$154,998	$8,027,409	98.1%	46,494	$0	0
JAN13	$10,260,341	$161,363	1.6%	791	$10,098,978	$180,229	$9,918,749	98.2%	57,184	$0	0
FEB13	$9,578,327	$137,631	1.4%	604	$9,440,696	$169,659	$9,271,036	98.2%	54,120	$0	0
MAR13	$10,275,691	$122,188	1.2%	458	$10,153,503	$193,016	$9,960,488	98.1%	57,152	$0	0
APR13	$10,437,916	$186,567	1.8%	817	$10,251,349	$183,691	$10,067,658	98.2%	58,280	$0	0
MAY13	$10,790,201	$88,460	0.8%	325	$10,701,741	$174,108	$10,527,634	98.4%	60,491	$0	0
JUN13	$8,814,218	$103,187	1.2%	425	$8,711,031	$140,564	$8,570,467	98.4%	46,750	$0	0
FY12-13	**$116,367,411**	**$2,938,545**	**2.5%**	**8,235**	**$113,428,866**	**$2,057,392**	**$111,371,474**	**98.2%**	**642,897**	**$0**	**0**
Statewide	**$2,567,475,896**	**$104,321,260**	**4.1%**	**425,147**	**$2,463,154,636**	**$129,763,039**	**$2,333,391,598**	**94.7%**	**11,907,471**	**$240,828**	**789**

DENIED CLAIMS

The following tables provide a summary of SD/MC denied claims processed during FY12-13. The data presents claims processed by the State as of November 2013 and may not yet include all original or replacement claim transactions for FY12-13. MHPs have 15 months from the service month for replacement claim transactions to correct and convert denied claims to approved claims.

Figure D-2. Denied Claims by Reason – Statewide Top 10 (FY12-13)
Claims Processed as of November 2013

Denial Code Description	Denial Code	Number Claims	Gross Dollars Denied	Percent Denied
Other health coverage must be billed before the submission of this claim.	CO 22	86,004	$18,657,343	17.9%
Medicare must be billed prior to the submission of this claim.	CO 22 N192	85,464	$18,505,933	17.7%
Beneficiary not eligible. Aid code invalid for DHCS.	CO 177,CO 31	39,732	$9,196,747	8.8%
Emergency Services Indicator must be "Y" or Pregnancy Indicator must be "Y" for this aid code.	CO 204 N30	28,935	$6,313,852	6.1%
Service line is a duplicate and a repeat service procedure modifier is not present.	CO 18 M86	35,150	$5,496,524	5.3%
Invalid procedure code and modifier combination. Service Facility Location provider NPI is not eligible to provide this service.	CO 109 M51,CO B7 N65	22,839	$5,448,775	5.2%
Aid code invalid for DHCS.	CO 31	15,721	$4,713,495	4.5%
Beneficiary not eligible. TBS valid only with Full Scope Aid Code and an EPSDT Aid Code. Aid code invalid for DHCS.	CO 177,CO 204,CO 31	22,762	$4,551,006	4.4%
Service Facility Location provider NPI is not eligible to provide this service within the submitting county.	CO B7	15,411	$3,855,122	3.7%
Only SED services are valid for Healthy Families aid code.	CO 185	16,441	$3,566,065	3.4%

Figure D-3. Denied Claims by Reason – San Diego Top 5 (FY12-13)
Claims Processed as of November 2013

Denial Code Description	Denial Code	Number Claims	Gross Dollars Denied	Percent Denied
Other health coverage must be billed before the submission of this claim.	CO 22	3,811	$936,060	31.9%
Number of units billed exceeds the maximum days allowed.	CO A1 M53	240	$788,982	26.8%
Services overlap an inpatient stay (service may be billed only if rendered on date of admission or date of discharge).	CO A1 MA133	180	$238,843	8.1%
Service line is a duplicate and a repeat service procedure modifier is not present.	CO 18 M86	988	$133,393	4.5%
Aid code invalid for DHCS.	CO 31	282	$96,627	3.3%

RETENTION RATES

Figure D-4. Retention Rates
San Diego CY09-CY12 and Statewide CY12

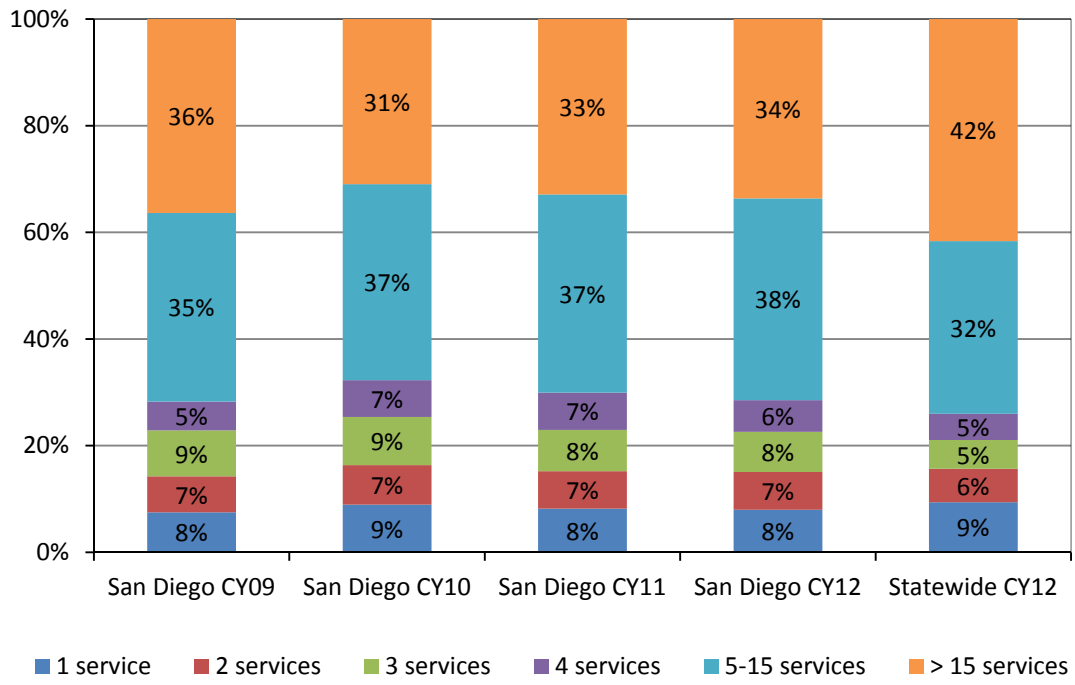


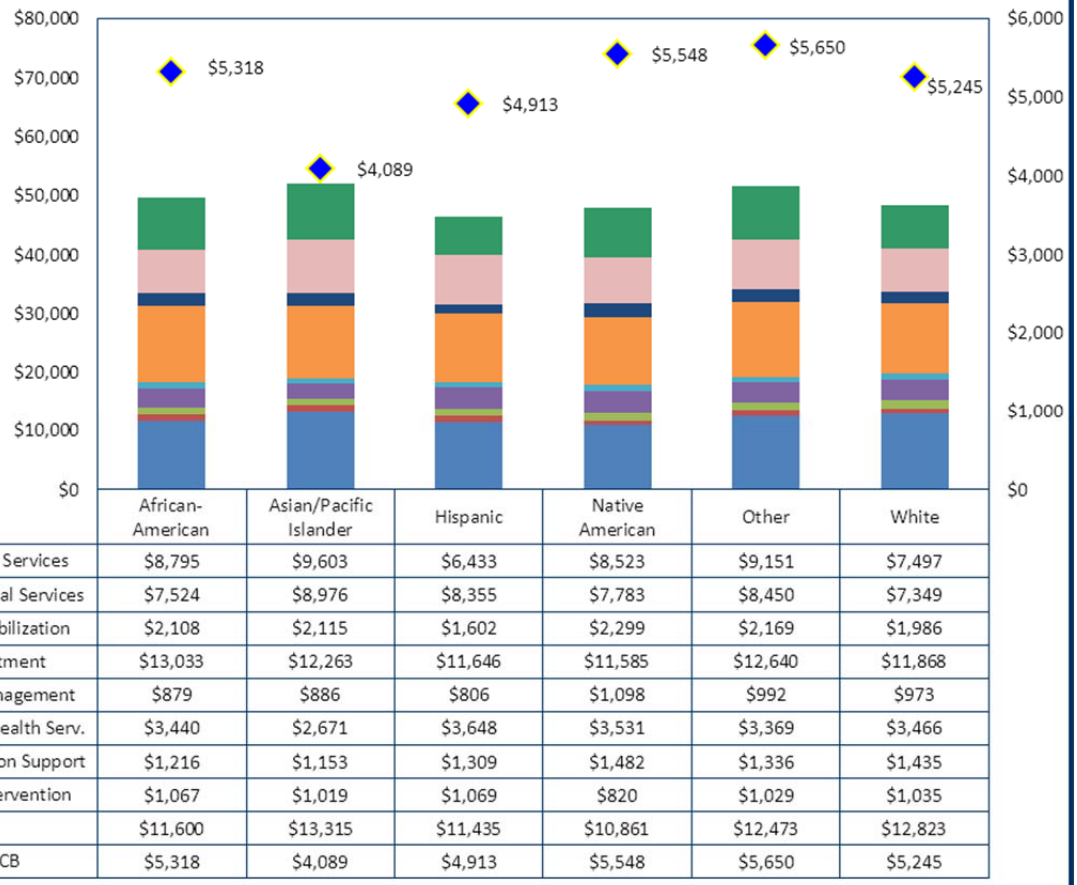
Figure D-5. CY12 Retention Rates with Average Approved Claims per Category

Number of Services Approved per Beneficiary Served	San Diego Number of beneficiaries served	San Diego $ per beneficiary served	Statewide $ per beneficiary served
1 service	2,539	$164	$338
2 services	2,254	$305	$520
3 services	2,399	$468	$675
4 services	1,895	$528	$815
5 – 15 services	12,047	$1,211	$1,672
> 15 services	10,708	$8,862	$10,637

SERVICE TYPE BY ETHNICITY - STATEWIDE

The following stacked bar charts show the average claims by service modality and ethnicity. It should be noted that these elements are not additive (i.e., the height of the bar has no meaning), and the main use for comparison is the differential use of particular services across various ethnicities. The blue diamond shows the average approved claims by ethnicity for all service modalities. Again, there is no direct relationship between the height of the bar (claims per service modality) and the average claims for that ethnicity.

Figure D-6. Statewide Approved Claims per Beneficiary CY12 - Race/Ethnicity by Service Type



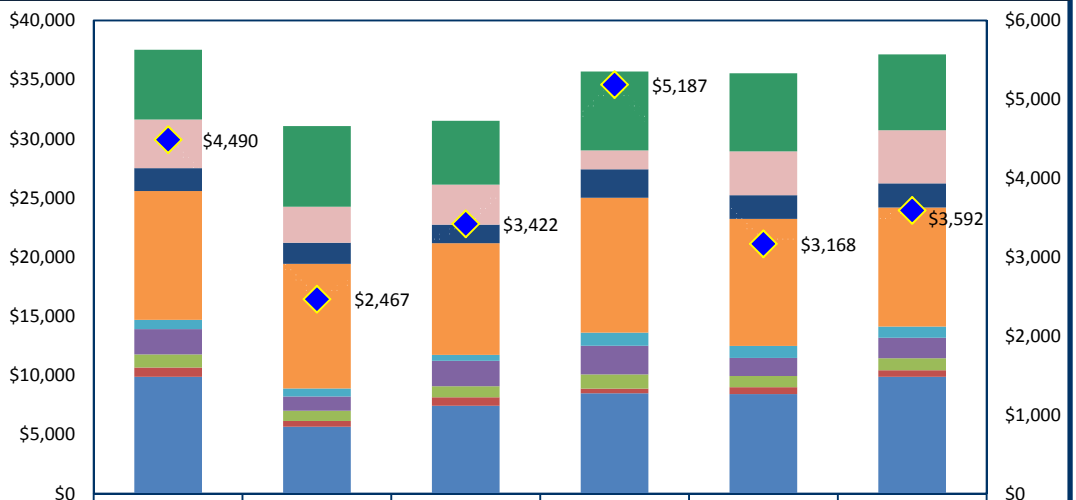
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	$8,795	$9,603	$6,433	$8,523	$9,151	$7,497
Residential Services	$7,524	$8,976	$8,355	$7,783	$8,450	$7,349
Crisis Stabilization	$2,108	$2,115	$1,602	$2,299	$2,169	$1,986
Day Treatment	$13,033	$12,263	$11,646	$11,585	$12,640	$11,868
Case Management	$879	$886	$806	$1,098	$992	$973
Mental Health Serv.	$3,440	$2,671	$3,648	$3,531	$3,369	$3,466
Medication Support	$1,216	$1,153	$1,309	$1,482	$1,336	$1,435
Crisis Intervention	$1,067	$1,019	$1,069	$820	$1,029	$1,035
TBS	$11,600	$13,315	$11,435	$10,861	$12,473	$12,823
Overall ACB	$5,318	$4,089	$4,913	$5,548	$5,650	$5,245

Note: The left axis refers to the columns, and the right refers to the diamonds (overall ACB for each category)

Figure D-7. Statewide Number of Beneficiaries Served CY12 - Race/Ethnicity by Service Type						
	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
All	73,641	28,112	164,001	3,299	44,391	156,207
Inpatient Services	6,324	1,713	10,405	293	4,274	12,891
Residential Services	871	221	691	47	831	2,370
Crisis Stabilization	6,991	1,412	7,700	265	3,709	10,543
Day Treatment	1,304	185	1,301	43	594	1,740
Case Management	31,017	11,332	64,914	1,497	19,193	63,856
Mental Health Serv.	58,075	21,451	143,412	2,650	34,236	123,718
Medication Support	39,280	17,653	63,114	1,621	26,677	85,861
Crisis Intervention	7,547	1,731	13,210	451	4,839	19,288
TBS	1,229	121	2,792	55	798	2,795

SERVICE TYPE BY ETHNICITY - MHP

Figure D-8. San Diego Approved Claims per Beneficiary CY12 - Race/Ethnicity by Service Type



	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
Inpatient Services	$5,897	$6,824	$5,405	$6,662	$6,613	$6,414
Residential Services	$4,111	$3,041	$3,376	$1,597	$3,696	$4,487
Crisis Stabilization	$1,936	$1,784	$1,572	$2,410	$2,001	$2,044
Day Treatment	$10,884	$10,531	$9,435	$11,404	$10,743	$10,062
Case Management	$791	$681	$507	$1,101	$1,013	$943
Mental Health Serv.	$2,139	$1,212	$2,143	$2,421	$1,532	$1,728
Medication Support	$1,103	$856	$934	$1,201	$946	$1,025
Crisis Intervention	$788	$491	$715	$395	$586	$550
TBS	$9,880	$5,659	$7,437	$8,489	$8,414	$9,879
Overall ACB	$4,490	$2,467	$3,422	$5,187	$3,168	$3,592

Note: The left axis refers to the columns, and the right refers to the diamonds (overall ACB for each category)

Figure D-9. San Diego Number of Beneficiaries Served CY12 - Race/Ethnicity by Service Type

	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
All	3,909	1,809	10,702	229	3,977	11,216
Inpatient Services	441	139	691	35	369	1,154
Residential Services	136	24	90	6	129	423
Crisis Stabilization	220	39	278	12	181	449
Day Treatment	301	37	489	18	61	379
Case Management	1,141	381	2,892	72	959	3,148
Mental Health Serv.	2,983	1,417	9,106	179	3,044	8,438
Medication Support	2,175	1,015	3,989	125	2,392	6,492
Crisis Intervention	207	49	482	17	165	625
TBS	91	18	334	7	50	191

HIGH COST BENEFICIARIES

Figure D-10. Statewide High-Cost Beneficiaries CY12

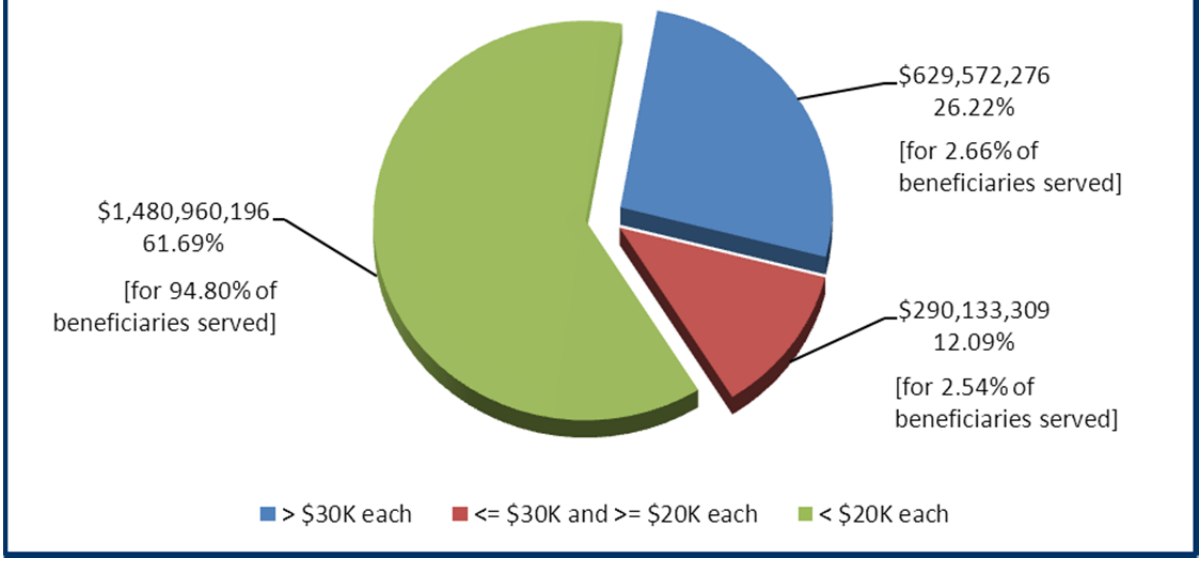
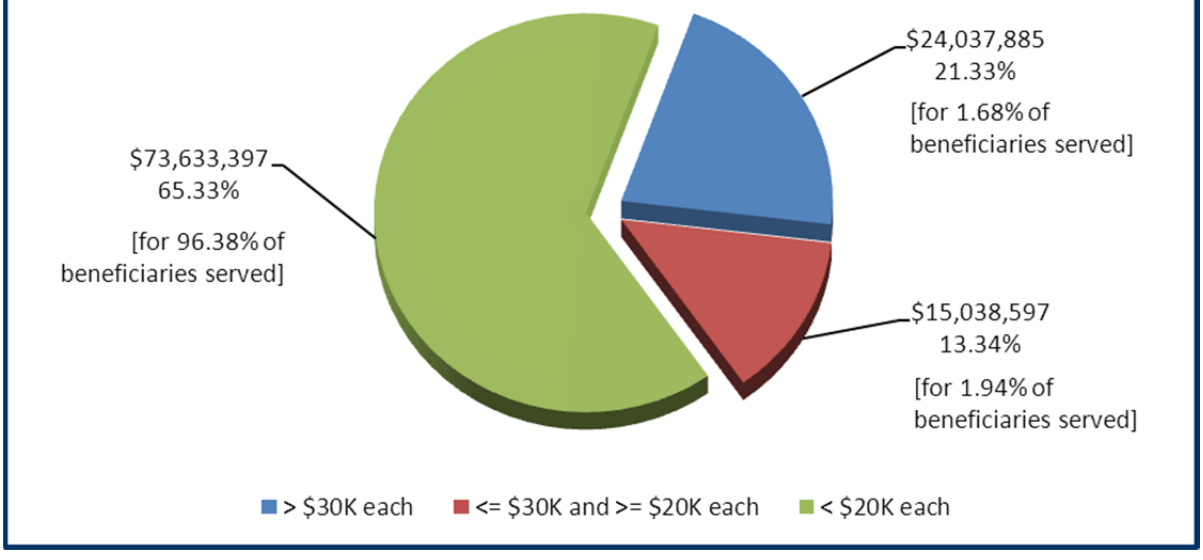


Figure D-11. San Diego High-Cost Beneficiaries CY12



EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

- Approved claims for Hispanic beneficiaries are now at parity with White beneficiaries. While the relative penetration rate disparity has decreased significantly, due to both a decrease in White penetration rate and an increase in Hispanic penetration rate, there remains a continued notable disparity in access.
- The relative access and the average approved claims for female beneficiaries are lower than for males. These disparities have remained relatively stable over the last five years.

For each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. The first figure compares approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the Hispanic penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Hispanics when compared to Whites. The approved claims ratio is calculated by dividing the average approved claims for Hispanics by the average approved claims for Whites. Similar calculations follow in the second figure for female to male beneficiaries.

For all elements, ratios depict the following:

- 1.0 = parity between the two elements compared
- Less than 1.0 = disparity for Hispanics or females
- Greater than 1.0 = no disparity for Hispanics or females. A ratio of greater than one indicates higher penetration or approved claims for Hispanics when compared to Whites or for females when compared to males.

Figure D-12. Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY12	164,001	3.81%	156,207	10.14%	$4,913	$5,245	.38	.94
San Diego CY12	10,702	4.79%	11,216	11.90%	$3,422	$3,592	.40	.95
San Diego CY11	10,733	4.79%	11,772	12.46%	$3,156	$3,189	.38	.99
San Diego CY10	10,044	4.98%	11,591	13.15%	$3,099	$2,993	.38	1.04
San Diego CY09	9,938	5.03%	12,166	13.61%	$3,266	$3,263	.37	1.00

Figure D-13. Examination of Disparities—Female versus Male								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female		Male		Female	Male	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY12	237,195	5.31%	232,456	6.66%	$4,593	$5,640	.80	.81
San Diego CY12	16,113	6.18%	15,729	7.91%	$3,092	$3,998	.78	.77
San Diego CY11	16,012	6.18%	15,514	7.88%	$2,800	$3,691	.79	.76
San Diego CY10	15,543	6.71%	14,785	8.29%	$2,645	$3,639	.81	.73
San Diego CY09	16,610	7.13%	15,154	8.65%	$2,905	$3,757	.82	.77

ELIGIBLES VERSUS BENEFICIARIES SERVED - FOSTER CARE

Figure D-14. San Diego Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Foster Care CY12

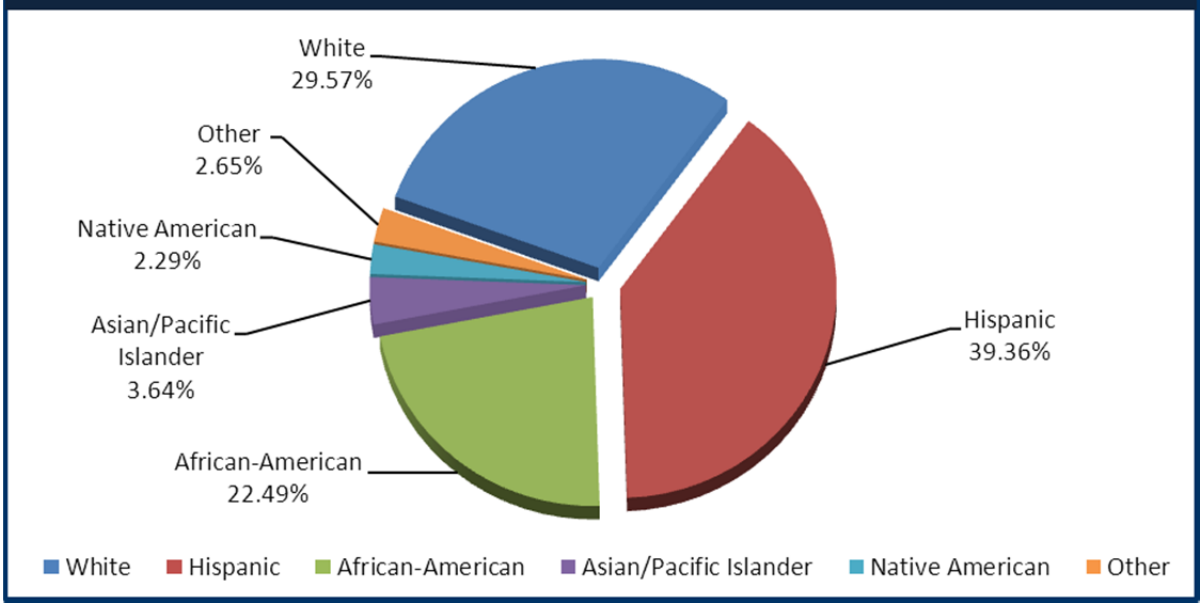
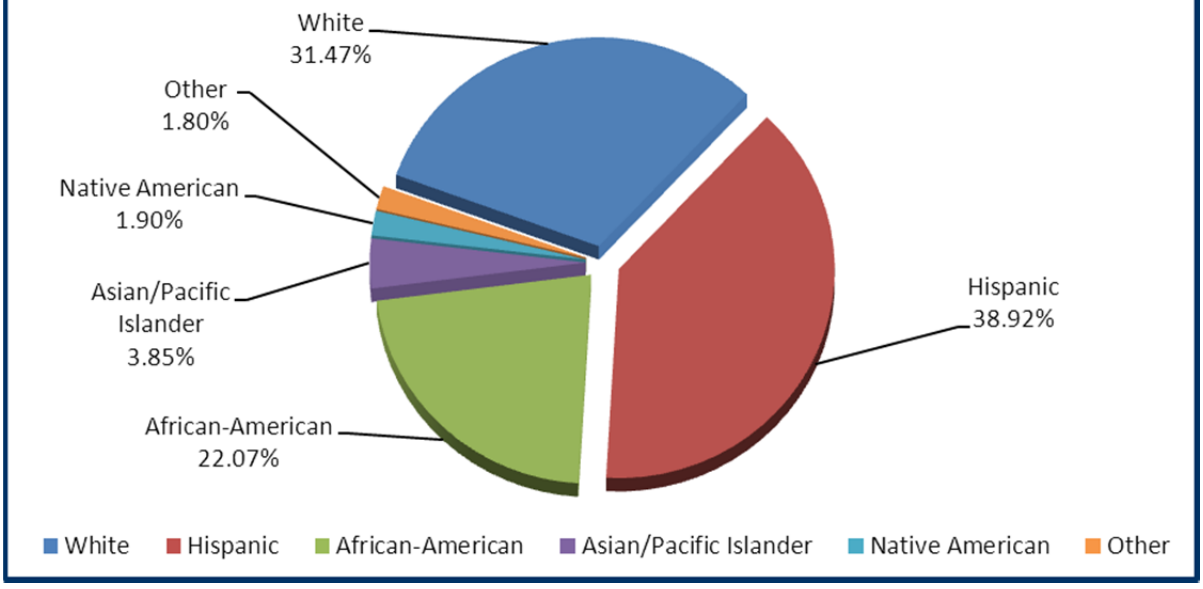


Figure D-15. San Diego Medi-Cal Beneficiaries Served, by Race/Ethnicity - Foster Care CY12



ELIGIBLES VERSUS BENEFICIARIES SERVED - TRANSITION AGE YOUTH

Figure D-16. San Diego Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Transition Age Youth CY12

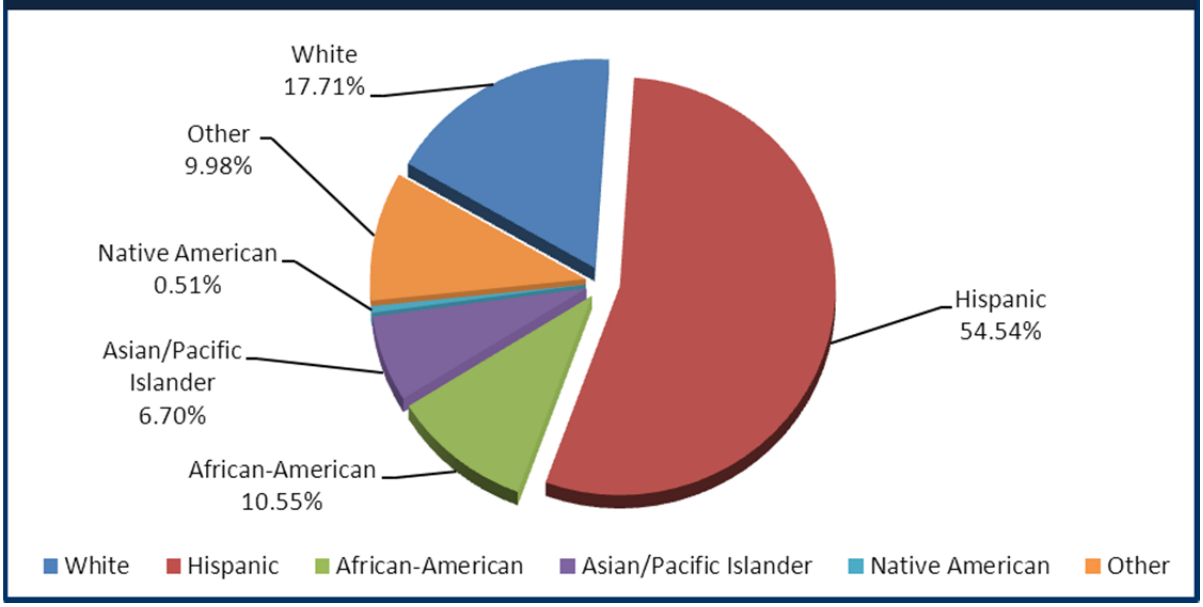
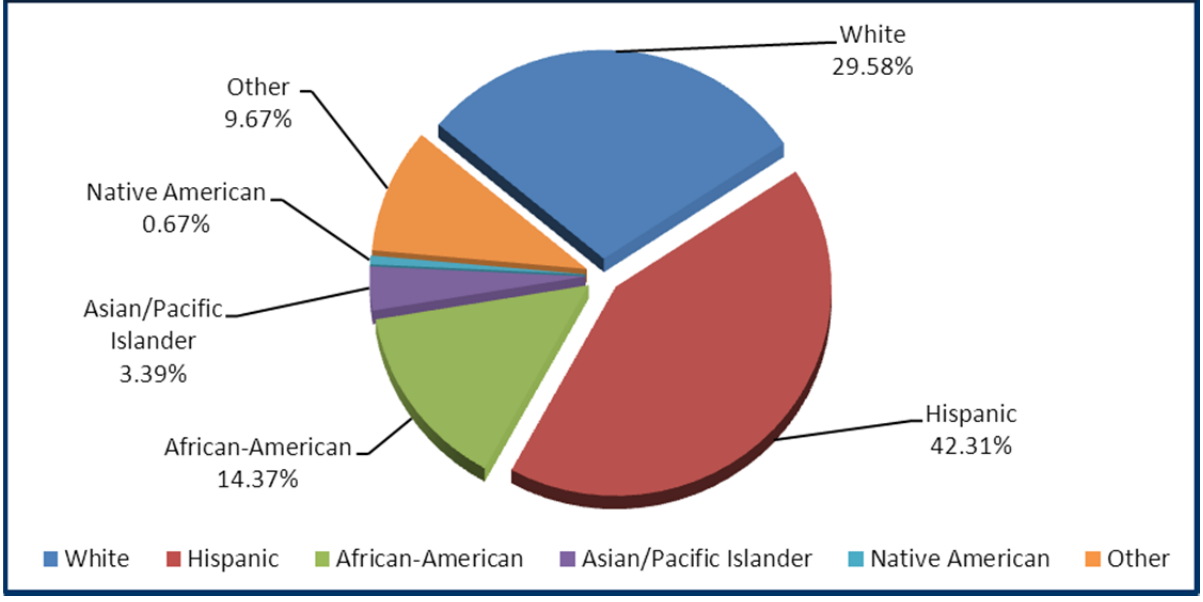


Figure D-17. San Diego Medi-Cal Beneficiaries Served, by Race/Ethnicity - Transition Age Youth CY12



E. Attachment—PIP Validation Tool

FY13-14 Review of: San Diego ☒ Clinical ☐ Non-Clinical

PIP Title: Reducing Adult/Older Adult Hospital Readmissions

Date PIP Began: May 2013

PIP Category: ☐Access ☐Timeliness ☐Quality ☒Outcomes ☐Other

Descriptive Category: Use of Acute Inpatient Services

Target Population: Adults and Older Adults

Step		Rating				Comments/Recommendations
		Met	**Partial**	**Not Met**	**N/A**	
1	**Study topic** *The study topic: Adult/older adult readmission to FFS hospitals within 30 days of discharge*					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	**X**				
1.2	Was selected following data collection and analysis of data that supports the identified problem	**X**				
1.3	Addresses key aspects of care and services	**X**				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs		**X**			Includes FFS and not County-operated psychiatric hospitals, with no explanation and no stated plans to include that population in the future. Since the exclusion is not explained, the MHP has not assured that consumers with special needs have not been excluded.
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	**X**				
Totals for Step 1:		**4**	**1**			
2	**Study Question Definition** *The written study question: "How can we decrease the rate of readmissions to psychiatric inpatient care following discharge? How can we improve the ability of recently discharged patients to live successfully outside of inpatient care?" Later on in the*					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	PIP document, the study question is revised to ask, "If enhanced awareness and intervention will reduce psychiatric inpatient readmissions."					
2.1	Identifies the problem targeted for improvement	X				Reduction of readmissions and improvement in consumers' ability to live outside of hospitals.
2.2	Includes the specific population to be addressed		X			Needs to specify all adults and older adults discharged from inpatient (FFS or County?) and then readmitted or County?) within 30 days of discharge.
2.3	Includes a general approach to interventions		X			"…enhanced awareness and intervention," needs to specify by whom and for whom.
2.4	Is answerable/demonstrable	X				With modifications in #2.2 and 2.3 above, as well as question re-framing to: "If we xxxx, then can we xxx?"
2.5	Is within the MHP's scope of influence	X				
Totals for Step 2:		**3**	**2**			
3	**Clearly Defined Study Indicators** *The study indicators: Adult/older adult readmissions within 30 days of discharge from FFS hospitals, June 2013 through November 2013*					
3.1	Are clearly defined, objective, and measurable		X			One indicator is provided, although additional opportunities to study consumer outcomes were identified.
3.2	Are designed to answer the study question		X			Readmission rates are answerable, but "live successfully outside of inpatient care" is not addressed.
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				Inpatient readmission within 30 days of discharge is a mental health outcome
3.4	Have accessible data that can be collected for each indicator	X				The MHP is provided with data entered into there is that is then compiled monthly and presented quarterly by their ASO
3.5	Utilize existing baseline data that demonstrate the current status for each indicator		X			The MHP's readmission rate was given as 23 % and 41% for the same time period. That baseline will need to be clarified. The MHP utilized a baseline mean of 123 readmissions per month
3.6	Identify relevant benchmarks for each	X				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	indicator					
3.7	Identify a specific, measurable goal(s) for each indicator	X				A mean of 111 readmissions per month for June to November 2013, a 10% reduction from the June to November 2012 baseline of 123,
Totals for Step 3:		**4**	**3**			
4	**Correctly Identified Study Population** *The method for identifying the study population: CAEQRO assumes the actual study population is : All adult and older adult consumers who were discharged from psychiatric care at FFS hospitals, not including SDCPH, from June 2013 to November 2013.*					
4.1	Is accurately and completely defined		X			Inconsistent references, including "adults," "adults and older adults," "recently discharged patients," "those discharged from FFS hospitals," "all individuals who have been discharged," etc. Also, since it is specified, the time frames need to be specifically included.
4.2	Included a data collection approach that captures all consumers for whom the study question applies		X			"All adult individuals discharged from psychiatric inpatient care in San Diego County, based on report run" from the MHP's IS. Omits reference to older adults, and omits reference to FFS hospitals only.
Totals for Step 4:			**2**			
5	**Use of Valid Sampling Techniques** *The sampling techniques: Entire population was tracked*					
5.1	Consider the true or estimated frequency of occurrence in the population				X	
5.2	Identify the sample size				X	
5.3	Specify the confidence interval to be used				X	
5.4	Specify the acceptable margin of error				X	
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population				X	
Totals for Step 5:					**5**	
6	**Accurate/Complete Data Collection** *The data techniques: Compare the mean monthly adult readmissions from June to November 2013 with the mean monthly*					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	readmissions for the same months the previous year.					
6.1	Identify the data elements to be collected	X				
6.2	Specify the sources of data	X				IS entries may or may not be a reliable data source.
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X				
6.4	Provides a timeline for the collection of baseline and remeasurement data	X				
6.5	Identify qualified personnel to collect the data	X				
Totals for Step 6:		**5**				
7	**Appropriate Intervention and Improvement Strategies** *The planned/implemented intervention(s) for improvement: Readmission Workgroup brainstorming, viewing presentations, and compiling a best practice document, and ASO providing data and reports.*					
7.1	Are related to causes/barriers identified through data analyses and QI processes		X			Data presented only for readmission baselines, rather than barriers
7.2	Have the potential to be applied system wide to induce significant change	X				
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X		Not addressed. "the plan is to report numbers in an unbiased fashion," does not allow for contingencies such as IS malfunction, etc.
7.4	Are standardized and monitored when an intervention is successful		X			
Totals for Step 7:		**1**	**2**	**1**		
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results: Mean monthly mean June to November 2012 was 123.2. Mean monthly mean June to November 2013 was 96.7, a 22% increase.*					
8.1	Are conducted according to the data analyses plan in the study design	X				
8.2	Identify factors that may threaten internal or external validity	X				Time lag in compiling data, questions about whether improvements can be attributed to meetings and discussions, inconsistent FFS hospital participation, unknown if all hospitals implemented best practices.

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
8.3	Are presented in an accurate, clear, and easily understood fashion	X				Line graph of the two years with monthly means, and numerical summaries and a completed Table D.
8.4	Identify initial measurement and remeasurement of study indicators	X				
8.5	Identify statistical differences between initial measurement and remeasurement	X				Paired sample measurements are presented on three charts, but there is no written interpretation for the numerical findings, so stakeholders may not understand the significance.
8.6	Include the interpretation of findings and the extent to which the study was successful	X				
Totals for Step 8:		**6**				
9	**Improvement Achieved** *There is evidence for true improvement based on: Comparison of mean monthly readmissions for the 6-month periods*					
9.1	A consistent baseline and remeasurement methodology	X				
9.2	Documented quantitative improvement in processes or outcomes of care	X				
9.3	Improvement appearing to be the result of the planned interventions(s)			X		The MHP questions whether the meetings and the document caused the improvement, as they can't reliably assure that the best practices were utilized.
9.4	Statistical evidence for improvement	X				
Totals for Step 9:		**3**		**1**		
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:*					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			X		Only one repeated measurement has been competed.
Totals for Step 10:				**1**		

FY13-14 Review of: San Diego ☐ Clinical ☒ Non-Clinical

PIP Title: Trauma – Informed Care Interventions

Date PIP Began: February 2013

PIP Category: ☐Access ☐Timeliness ☐Quality ☒Outcomes ☐Other

Descriptive Category: Improved treatment processes

Target Population: Children and their caregivers, adults and older adults

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	**Study topic** *The study topic: Informing and educating staff and providers about trauma in order to promote consumer safety and satisfaction*					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	X				Nationally, 59% of the general population report at least one adverse childhood event (ACE) and 37.4% of San Diego Behavioral consumers reported childhood trauma, and 29.4% reported having been abused as a child. In addition, staff surveys revealed that 44% knew about Trauma Informed Care (TIC) and 34% knew how to apply TIC.
1.2	Was selected following data collection and analysis of data that supports the identified problem		X			Staff findings were compiled using interviews, surveys and site visits/observations. Consumers were provided with several types of written surveys. There is no discussion about how provider input/surveys were obtained.
1.3	Addresses key aspects of care and services	X				Safety and satisfaction of consumers, and knowledge and competencies of staff providers
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	X				Includes all consumers, child, adult and older adult served at Southeast Mental Health Clinic, potentially 472 TAY, adults and older adults, and 176 children and youth.
1.5	Has the potential to improve consumer mental health outcomes, functional status,	X				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	satisfaction, or related processes of care designed to improve same					
Totals for Step 1:		**4**	**1**			
2	**Study Question Definition** *The written study question: "Will targeted interventions at the Southeast MH Clinic, including trauma informed care training, staff development, change in practices and creating a warm and welcoming environment result in increased staff trauma informed care competences and consumer satisfaction?"*					
2.1	Identifies the problem targeted for improvement	**X**				
2.2	Includes the specific population to be addressed	**X**				Need to include providers
2.3	Includes a general approach to interventions	**X**				
2.4	Is answerable/demonstrable	**X**				
2.5	Is within the MHP's scope of influence	**X**				
Totals for Step 2:		**5**				
3	**Clearly Defined Study Indicators** *The study indicators: Staff TIC self assessment, Safe and Secure consumer survey, and 2 adult and 2 youth and 1 caregiver satisfaction surveys*					
3.1	Are clearly defined, objective, and measurable	**X**				
3.2	Are designed to answer the study question	**X**				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	**X**				
3.4	Have accessible data that can be collected for each indicator		**X**			No numerators or denominators are included for consumers' satisfaction scores, and both the staff self-assessment and the consumer safety survey only include baseline percentages, so none of the data allows for understanding of the size of respondent populations.
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	**X**				Baseline scores
3.6	Identify relevant benchmarks for each indicator				**X**	
3.7	Identify a specific, measurable goal(s) for			**X**		There are no targeted goals for these indicators

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	each indicator					
Totals for Step 3:		**4**	**1**	**1**	**1**	
4	**Correctly Identified Study Population** *The method for identifying the study population: 14 staff at the clinic, and 54 completed surveys of a potential consumer population of 648 at the clinic*					
4.1	Is accurately and completely defined	**X**				Needs specific number of potentially eligible staff so the significance of 14 respondents is understood. "Majority' is too vague.
4.2	Included a data collection approach that captures all consumers for whom the study question applies		**X**			The TIC anonymous on-line staff survey was planned for pre and post interventions. and was originally performed in 2012 and then performed in August 2013, with a follow-up survey planned for August 2014. There are no specifics about the number of staff in the 2012 survey, or if the same 14 participated in 2013. The anonymous paper consumer satisfaction surveys for adults and children and their caregivers were performed annually, including in August 2012 and 2013 and will be repeated in August 2014, for pre-mid and post results. The consumer safety survey was performed initially in April 2013 and will be repeated in April 2014. The anonymous paper consumer satisfaction survey description includes a specified two-week interval for distribution, but the methodology of selection and administration is not detailed for any of the 3 types of surveys.
Totals for Step 4:		**1**	**1**			
5	**Use of Valid Sampling Techniques** *The sampling techniques:*					
5.1	Consider the true or estimated frequency of occurrence in the population		**X**			There is no denominator provide for the 14 staff surveyed, only that they are "the majority", 8.8% (54) of the potential consumers population (648) returned the safety survey, and the range of respondents to the consumer satisfaction surveys over two years was from 4 to 24.

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
5.2	Identify the sample size		X			As discussed in #5.1 above
5.3	Specify the confidence interval to be used			X		The only reference to confidence is that a sample of 30 or more is considered as statistically significant
5.4	Specify the acceptable margin of error			X		
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population		X			
Totals for Step 5:		**0**	**3**	**2**		
6	**Accurate/Complete Data Collection** *The data techniques: annual collection of consumer satisfaction surveys, and "special" surveys – TIC for staff and the Safe and Secure Environment survey for consumers, which is offered in English and Spanish*					
6.1	Identify the data elements to be collected	X				Related domains are identified
6.2	Specify the sources of data	X				
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data		X			As discussed, methodology needs more specificity to ensure consistency
6.4	Provides a timeline for the collection of baseline and remeasurement data	X				
6.5	Identify qualified personnel to collect the data	X				
Totals for Step 6:		**4**	**1**			
7	**Appropriate Intervention and Improvement Strategies** *The planned/implemented intervention(s) for improvement: Biweekly Clinic staff and community parterres meet to discuss affected consumers, environmental Clinic changes, including lighting, noise reduction, artwork, cal TV shows, addition of a positive comment tree.*					
7.1	Are related to causes/barriers identified through data analyses and QI processes	X				
7.2	Have the potential to be applied system wide to induce significant change	X				
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X		The PIP specifies that there are no contingencies for untoward results, but will also need to look at methodology which may require flexibility/modifications.
7.4	Are standardized and monitored when an				X	Pending April 20104 survey outcomes

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	intervention is successful					
Totals for Step 7:		**2**	**0**	**1**	**1**	
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results: Comparisons provided for consumer/caregiver satisfaction scores from April 2012 to April 2013, and baseline staff TIC self-assessment and consumer safety survey.*					
8.1	Are conducted according to the data analyses plan in the study design		**X**			
8.2	Identify factors that may threaten internal or external validity	**X**				The small number of respondents
8.3	Are presented in an accurate, clear, and easily understood fashion	**X**				Staff TIC baseline results was 85.7% had TIC in the training, 35.7% learned how to apply TIC and 28% knew how to ask and respond to trauma disclosure. Consumers" safety survey result was 89% agree to feeling welcomed, 83% felt the waiting room was welcoming, and 91% felt comfortable in the facility. Consumer satisfaction scores and agreement rates were provided for the 5 age-specific 2012 and 2013 pre and mid-intervention surveys.
8.4	Identify initial measurement and remeasurement of study indicators	**X**				
8.5	Identify statistical differences between initial measurement and remeasurement				**X**	Too early in the project. Results for pre, mid and post interventions will be complied after the April 2014 remeasurements are completed.
8.6	Include the interpretation of findings and the extent to which the study was successful				**X**	
Totals for Step 8:		**3**	**1**		**2**	
9	**Improvement Achieved** *There is evidence for true improvement based on:*					
9.1	A consistent baseline and remeasurement methodology				**X**	
9.2	Documented quantitative improvement in processes or outcomes of care				**X**	
9.3	Improvement appearing to be the result of the				**X**	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	planned interventions(s)					
9.4	Statistical evidence for improvement				X	
Totals for Step 9:					4	
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:*					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant				X	Plans for ongoing monitoring after April 2014, as well as system-wide implementation, are not addressed
Totals for Step 10:					X	

F. Attachment—MHP PIPs Submitted

APS Healthcare

California EQRO

Feb 2013 – Updates to document noted in blue.

- This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses in evaluating PIPs. The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. The MHP is not limited to using this format and may submit evidence of the PIP in other formats which address the required elements.
    - PDSA Cycles can be submitted as separate documents or outlined as part of #3 barrier analysis (understanding causes), #10 interventions (testing change ideas), as well as #15 data analysis and triggering changes. Conducting PDSA cycles is for purposes of learning and testing; many PDSA cycles in themselves do not complete a PIP.
- Your PIP should focus on a consumer-related problem (access, timeliness, outcomes) which is measured (indicators), for which interventions will be applied to create improvement. Simply setting up a monitoring system for some facet of care is not a PIP unless it is focused on improving an indicator.
- Do not set up a PIP to evaluate the effectiveness of a given program; this is a program evaluation. The individuals receiving the intervention need to be related to the identified problem, upon which various interventions (not just a program's services) can be tested and applied to create improvement.
- You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.
- Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."
- PIPs generally should not last longer than roughly two years. An MHP is advised to consult with CAEQRO before continuing a PIP into a third year.

CAEQRO PIP Outline via Road Map

MHP: County of San Diego, Behavioral Health Services
Date PIP Began: May 2013 (first meeting of Readmissions Workgroup)

Title of PIP: Reducing Adult/Older Adult Hospital Readmissions
Clinical or Non-Clinical: Clinical

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

This PIP was written and edited by the Performance Improvement Team of County of San Diego Behavioral Health Services, Quality Improvement unit (BHS-QI).

Much of the information and ideas contained in this PIP came from meetings of the Hospital Readmission Workgroup, which met on a monthly basis from May through December 2013. The Core Hospital Readmissions Workgroup performed the central planning regarding the agenda for the meetings of the larger Hospital Readmissions Workgroup. The larger Hospital Readmissions Workgroup included representatives of BHS-QI, Optum Health, San Diego County Psychiatric Hospital (SDCPH), hospitals in San Diego County and the Hospital Association of San Diego and Imperial Counties (HASDIC), and contracted providers of services in San Diego County (including Community Research Foundation and Mental Health Systems, Inc.)

1. Core Hospital Readmissions Workgroup members:
    - Tabatha Lang, MFT - County of San Diego, Behavioral Health Services, Quality Improvement, Chief
    - Mitchell Gluck, MSW, MBA – San Diego County Psychiatric Hospital, Assistant Administrator
    - Liz Miles, MPH, MSW -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Principal Administrative Analyst
    - Michael J. Bailey, M.D. – OptumHealth, Medical Director
    - Michael Krelstein, M.D. -- County of San Diego, Behavioral Health Services, Clinical Director
    - Ana Briones-Espinoza, MBA – OptumHealth
    - Jenelle Singer, MPH -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Research Analyst
    - Brian Hammond, MBA, M.S. -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Research Analyst

2. Hospital Readmissions Workgroup members:
    - Alicia Munoz – CHA / HASDIC
    - Aliza Barzilay – MHS, Inc. / Hope Connections
    - Ana Briones-Espinoza, MBA – OptumHealth
    - Dianna Panizzon, Psy.D. – Bridge to Recovery / UCSD
    - Mitchell Gluck, MSW, MBA -- San Diego County Psychiatric Hospital, Assistant Administrator
    - William (Hobie) Hawthorne, Ph.D. – Community Research Foundation, Executive Director
    - Joyce Thompson – OptumHealth
    - Tabatha Lang, MFT - County of San Diego, Behavioral Health Services, Quality Improvement, Chief
    - Michael Krelstein, M.D. -- County of San Diego, Behavioral Health Services, Clinical Director
    - Liz Miles, MPH, MSW -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Principal Administrative Analyst
    - Paula Goncalves -- Community Research Foundation
    - Ronald Cann -- Community Research Foundation
    - Sharon Massoth, LCSW -- County of San Diego, Emergency Screening Unit, Program Manager
    - Jenelle Singer, MPH -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Research Analyst
    - George Scolari – Community Health Group
    - Julie Cole – MHS, Inc., Hope Connections
    - Robert Bryan – Bridge to Recovery / UCSD
    - Brian Hammond, MBA, M.S. -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Research Analyst
    - Diego Rogers -- Community Research Foundation
    - Virginia West -- County of San Diego, Behavioral Health Services, Adult / Older Adult
    - Anna Palid -- County of San Diego, Behavioral Health Services, Adult / Older Adult
    - Kristie Tokar – OptumHealth, Clinical Director
    - Debbie Malcarne -- County of San Diego, Behavioral Health Services, Adult / Older Adult
    - Lindsay Palmer, M.S. -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team
    - Jennifer Tuteur, M.D. – LIHP, OptumHealth
    - Michael J. Bailey, M.D. – OptumHealth, Medical Director
    - Terry Villacruz -- San Diego County Psychiatric Hospital
    - Scott Carruthers – Sharp Hospital
    - Dan Maccia -- Community Research Foundation, START programs
    - Christopher Lee – HASDIC
    - Fay Massian – MHS, Inc. / Hope Connections
    - Diane McGrogan – Sharp Mesa Vista
    - Judith Yates – HASDIC
    - Melissa Stout Penn – United Healthcare
    - Brenda Schmitthenner -- County of San Diego, HHSA, AIS

- Andrea Carlin – JFS Patient Advocacy
- Cassandra Chavez -- County of San Diego, Behavioral Health Services
- B. Myuderse – Rady Children's Hospital, San Diego
- Betsy Knight -- County of San Diego, Behavioral Health Services, County Case Management
- John Wilkie -- County of San Diego, Behavioral Health Services, County Case Management
- Brianna Forbes – Prime Health – Bayview Hospital

At the meetings of the Hospital Readmission Workgroup, presentations were given by representatives of programs that have reduced the readmissions of consumers who they have assisted. These programs are: Low Income Health Program (LIHP), County Case Management, Beacon Care Transitions, Special Help for At-Risk Individuals (SHARI), Telecare Transition Team, Hope Connections, and Bridge to Recovery. The Performance Improvement Team wrote and edited a document detailing Best Practices informed by these presentations, which is referenced in this PIP. This document is attached for your reference.

Additionally, this PIP uses information from reports on Readmissions authored by Optum Health and the Health Services Research Center (HSRC).

"Is there really a problem?"

2. Define the problem. Describe the data reviewed and relevant benchmarks that validate the problem exists. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

This PIP addresses the problem of the readmission rate of clients who have been discharged from inpatient psychiatric care. The readmission rate is defined as the percentage of clients who have been discharged from inpatient psychiatric care who are readmitted to inpatient care in less than 30 days. In fiscal year 2011-2012, the average cost of clients who readmitted was $16,292 per person, while the average cost of clients who did not readmit was $4,447 per person (source: Phase II: Fee-For-Service Hospitals Readmission Report, OptumHealth, 2/28/13). Given the greater cost of clients who readmit, it is clear that reducing readmission rates could result in a cost savings for the County of San Diego.

The readmission rate also serves as a proxy for understanding the rate at which individuals who are discharged from inpatient care are successfully recovering after discharge. By aiming to decrease readmission rates, this PIP aims to increase the rate of consumers of behavioral health services recovering successfully after discharge. Increased rates of successful recovery will result in an improved quality of life for clients. Individuals who successfully recover after discharge are likely to have better outcomes regarding housing (Herman, et al., 2011; Lindamer, et al., 2012), and employment (McGurk, Mueser, Harvey, LaPuglia, & Marder, 2003).

In fiscal year 2011-2012, San Diego County had a 30 day psychiatric readmission rate of 23%. This is lower than the average psychiatric readmission rate of the state of California, which was 25%.
However, it is higher than the average 30 day psychiatric readmission rate nationwide, which was 14% (source: Phase II: Fee-For-Service Hospitals Readmission Report, OptumHealth, 2/28/13; SR-8065).

The total cost of all psychiatric admissions to San Diego County was $15,653,572 in fiscal year 2011-2012. The 23% of patients who were rehospitalized accounted for 49% of total admissions and 53% of total cost, or $8,276,261. If the readmissions rate were brought down from 23% to the nationwide average of 14%, this would create a cost savings of approximately $2,428,225 or 16.5% of the total cost of all psychiatric admissions (source: Phase II: Fee-For-Service Hospitals Readmission Report, OptumHealth, 2/28/13; SR-8065).

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. a) What are the likely causes of the problem? Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

#1: One likely cause of the problem of readmissions is the lack of a timely follow-up appointment with outpatient services after discharge. There are three major sources of data supporting this.

The first source of data is an analysis of the psychiatric services history of the 14 individuals with the highest utilization rates of inpatient care in San Diego County over the period of FY 09/10 through FY 11/12. Only 58% of these individuals' discharges from hospitalization were followed by receiving services outside of the hospital within 7 days or sooner. 36% of discharges were followed by no services before the next readmission, while 6% of discharges were followed by services more than 7 days after discharge.

The second source of data is that the document "Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders" [Source: Reducing Avoidable Readmissions Effectively (RARE); Attachment C] recommends as best practices that a patient should have a follow-up appointment with a provider of behavioral health services within seven days post-discharge. The Care Transitions Intervention model, designed by Dr. Eric Coleman, has a goal of patients receiving a follow-up appointment within seven days after discharge. This program has been implemented in numerous locations and has successfully reduced readmissions rates (http://caretransitions.org/documents/Evidence_and_Adoptions_2.pdf). This model has been used successfully by the Beacon Care Transitions Intervention program in San Diego County, where an estimated $303,342 was saved due to decreased readmissions for the 298 individuals who completed the CTI program (source: BHS QI PIT, Readmissions Grid (Attachment A; presentation by Brenda Schmitthenner of AIS).

The third source of data is a paper which found that in San Diego County, having four or more outpatient visits in a year was correlated with decreased chances of being defined as a high utilizer of inpatient services (defined as three or more hospitalizations

within a year) (source: Lindamer, et al. (2012) "Predisposing, Enabling, and Need Factors Associated with High Service Use in a Public Mental Health System," pp. 200-209).

#2: Another likely cause of the problem of readmissions is that coordination of care could be enhanced. An individual's recovery will be better supported when that individual is consistently receiving services from the same care providers and when each provider knows what the other providers are doing. That way the individual is receiving services from providers who understand the client and the client's needs and history.

The first source of evidence for this comes from an analysis of the psychiatric services history of the 14 individuals with the highest utilization rates of inpatient care in San Diego County over the period of FY 09/10 through FY 11/12. Of 237 readmissions in a three-year span, 164 (69%) were to a different facility than the one that discharged the client (source: "Reducing Hospital Readmissions" report (Attachment B)).

The second source of evidence also comes from the analysis of the psychiatric services history of the 14 individuals with the highest utilization rates of inpatient care in San Diego County over the period of FY 09/10 through FY 11/12. In a three-year period these individuals saw an average of 10 fee-for-service outpatient providers each (ranging from a low of 4 providers to a high of 18 providers) (source: "Reducing Hospital Readmissions" report (Attachment B)).

b) What are barriers/causes identified that require intervention? Use Table A, and attach any charts, graphs, or tables to display the data.

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Lack of connection to services after hospital discharge	1. **Analysis of the psychiatric services history of the 14 individuals with the highest readmission rates to inpatient care in San Diego County over the period of FY 09/10 through FY 11/12.** 44% of discharges had no services within 7 days after discharge. 2. **Document "Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders"** (Attachment C) recommends outpatient follow-up appointment within 7 days after discharge. Programs that have worked to do this, such as the Care Transitions Intervention program created by Dr. Eric Coleman and the Beacon CTI program in San Diego modeled after Dr. Coleman's program, have shown results in decreasing readmissions rates. 3. **Lindamer et al. (2012)** found that in San Diego County, having four or more outpatient visits in a year was correlated with decreased chances of being defined as a high utilizer of inpatient services.
Coordination of care could be enhanced	1. **Analysis of the psychiatric services history of the 14 individuals with the highest readmission rates to inpatient care in San Diego County over the period of FY 09/10 through FY 11/12.** Of 237 readmissions in a three-year span, 164 (69%) were to a

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
	different facility than the one that discharged the client. 2. In a three-year period these individuals saw an average of 10 fee-for-service outpatient providers each (ranging from a low of 4 providers for Client 1 to a high of 18 providers for Client 4).

Formulate the study question

4. State the study question. This should be a single question in 1-2 sentences which specifically identifies the problem for improvement, the general intervention, and the desired outcome.

How can we decrease the rate of readmissions to psychiatric inpatient care following discharge? How can we improve the ability of recently discharged patients to live successfully outside of inpatient care?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain. (Remember that all PIPs must include Medi-Cal beneficiaries)

The recommended actions to help decrease readmissions rates may apply to all Behavioral Health Services beneficiaries receiving inpatient psychiatric services, of whom approximately 63% of adult clients (source: Adult / Older Adult BHS Databook for Fiscal Year 2012-13, published by HSRC) and 79% of child clients (source: CYF BHS Databook for Fiscal Year 2012-13, published by CASRC) are Medi-Cal beneficiaries.

Many of the lessons regarding best practices for reducing adult readmissions also apply to readmissions for children. In FY 12-13 there were 437 unique children hospitalized, and 61 were readmitted to the hospital within 30 days after discharge (source: Mental Health Dashboard, January 2014). For the purposes of measuring progress in this PIP we will only be considering adult readmissions, because the number of children readmitted to FFS hospitals is too small to be able to identify statistically meaningful trends over the period of less than a year since the PIP began.

6. Describe the population to be included in the PIP, including the number of beneficiaries.

This PIP includes all individuals who have been discharged from psychiatric care at FFS hospitals (not including the San Diego County Psychiatric Hospital) in San Diego County. In FY 11-12 there were 2,167 unique (unduplicated) adult individuals hospitalized (source: Phase II: Fee-For-Service Hospitals Readmission Report, OptumHealth, 2/28/13; SR-8065.) Of this population, 508 unique clients were readmitted to the hospital within 30 days post-discharge.

7. Describe how the population is being identified for the collection of data.

The population will be all adult individuals discharged from psychiatric inpatient care in San Diego County, based on reports run from San Diego County's Anasazi system.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

To track the overall trends in readmissions, no sampling was used. We tracked the readmission rates of the entire population of adults discharged from psychiatric hospitalization.

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

An average of 296 adults were admitted to FFS hospitals per month in FY 12-13 and there were an average of 122 readmissions per month. This population size is large enough to be analyzed and yield statistically significant results.

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

9. What indicators were selected to measure improvement?

The number of adults readmitted within 30 days post-discharge at FFS hospitals was selected as an indicator to measure performance.

a) Why were these performance indicators selected?

This indicator was selected because it represents the population this PIP addresses – to examine if enhanced awareness and intervention reduce psychiatric hospital readmissions. Furthermore, this indicator has large enough numbers that it is possible to discern statistically significant trends over a period of months. In FY 12-13 there were a total of 1,465 readmissions, with a mean of 122 readmissions per month.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?
Include process indicators that reflect monitoring the application of the interventions.

A decrease in the number of readmissions would indicate that fewer individuals are being re-hospitalized within 30 days after being discharged from hospitalization. This indicates an improvement in how well recently discharged individuals are recovering or adjusting to life outside of hospitalization. Individuals who are not readmitted to the hospital may have stabilized through accessing community services, so there is not a need to utilize inpatient services again after discharge. This supposition is supported by Lindamer et al.'s (2012) findings that accessing outpatient services four or more times in a year is associated with lower chances of being classified as a high utilizer of inpatient services, and homelessness and a co-occurring diagnosis of a substance abuse disorder is associated with higher chances of being classified as a high utilizer.

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

Table B – List of Performance Indicators, Baselines, and Goals

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
1	(A/OA) – Readmissions within 30 days @ FFS Hospitals (From Mental Health Board Dashboard Report). Measurement period begins June 2013 (the month after the Readmissions Workgroup begins meeting) and ends November 2013 (the last month for which data is available).	Number admissions to FFS hospitals within 30 days after the individual was discharged from inpatient psychiatric care.	None	The mean number of 30-day readmissions per month for June 2012-November 2012 was 123.2. The monthly mean for the 6-month period of June to November 2012 is the preferred baseline because the measurement period will be the same months in 2013.	A mean of 111 readmissions per month (a 10% reduction)

10. <u>Use Table C to summarize interventions</u>.

a) In column 2, describe each intervention.
b) In column 3, identify the barriers/causes each intervention is designed to address.
c) In column 4, identify the corresponding indicator which will measure the performance of each intervention.
d) Do not cluster different interventions together.

Table C - Interventions

1) Number of Intervention	2) List each specific intervention	3) Barrier(s)/causes each specific intervention is designed to target	4) Corresponding Indicator	5) Dates Applied
1	Stakeholders in the Readmissions Workgroup brainstorm unseen causes of readmission, data elements to consider, and "low-hanging fruit" (the most simple types of interventions that can have a positive effect on reducing	Lack of awareness about the problem of readmissions, lack of knowledge about the causes of readmissions, and lack of knowledge about how readmissions can be reduced	(A/OA) – Readmissions within 30 days @ FFS Hospitals	July 2013

1) Number of Intervention	2) List each specific intervention	3) Barrier(s)/causes each specific intervention is designed to target	4) Corresponding Indicator	5) Dates Applied
	readmissions) (see Attachment D: "Readmission Workgroup Themes")			
2	Stakeholders in the Readmissions Workgroup see presentations by representatives of 6 programs that work to reduce readmissions and/or connect clients to services and facilitate their transition to living outside of inpatient care. (See Attachment A.)	Lack of knowledge about how readmissions can be reduced	(A/OA) – Readmissions within 30 days @ FFS Hospitals	September – December 2013
3	Compile a document summarizing best practices for reducing readmissions and share this document with the stakeholders in the Readmissions Workgroup (See Attachment E.)	Lack of knowledge about how readmissions can be reduced	(A/OA) – Readmissions within 30 days @ FFS Hospitals	January – February 2014
4	Optum provided individual hospital readmission rates across the system and will continue to do so. (See Attachment F.)	Previously, hospitals could only calculate their readmission rates based on clients who return to them. Hospitals have a more complete picture of their readmission rates because this report includes clients re-admitted to different hospitals from the one they were discharged from.	FFS Inpatient Psychiatric Summary Readmission Rates	August 2013 - present

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

The figure for readmissions within 30 days at FFS hospitals is published in the monthly MHB Dashboard report.

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.

The data is collected from Anasazi, the information system used by County of San Diego BHS. The County of San Diego's Administrative Service Organization, OptumHealth, compiles this data and publishes it in the monthly MHB Dashboard report.

13. Describe the plan for data analysis. Include contingencies for untoward results.

The plan is to compare the mean monthly adult readmissions for June to November 2013 with the mean monthly readmissions for the same months in the previous year. This period was chosen because June 2013 is the month after the first meeting of the readmissions workgroup, and November 2013 is the last month for which data is available.

There are no contingencies for untoward results. The plan is to report the change in number of readmissions in an unbiased fashion, whether the numbers increase or decrease.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

Data are collected from the Anasazi software system by OptumHealth, the Administrative Service Organization contracted to provide data support to BHS. These data, including (A/OA) – Readmissions within 30 days @ FFS Hospitals, are published in the MHB Dashboard after review by the Performance Improvement Team of BHS Quality Improvement. The MHB Dashboard is reviewed by Brian Hammond, MBA, M.S., a Research Analyst on the PIT team of BHS-QI and a contractor through Rady Children's Hospital, and the final approval is given by Elizabeth Miles, MPH, MSW, the Principal Administrative Analyst of the PIT team of BHS-QI.

Data analysis for this PIP, and the writing of the PIP, is performed by Brian Hammond.

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

The data analysis occurred as planned. The results suggest that bringing key stakeholders' attention to the problem of readmissions and spreading information about best practices in reducing readmissions may be effective in beginning to reduce psychiatric admissions.

There is a major limitation is that there is a time lag in compiling data and bringing that data from Anasazi into the MHB Dashboard reports, such that data from November 2013 is the most current that was available at the time that this report was written. This allows us to compare only 6 months of data after the work of the Readmissions Workgroup began in May 2013. It is likely that it will take longer than 6 months for providers and hospitals to fully implement the suggested best practices that were discussed in Readmissions Workgroup meetings. Therefore, it may be months before it is possible to gauge the full extent to which readmissions were reduced by implementing the best practices that were discussed in Workgroup meetings.

There are a few other caveats that should be mentioned in interpreting the data and determining how much of the improvement in readmissions rates can be attributed to a series of meetings in which best practices are discussed. There are FFS hospitals in San Diego County that did not have representatives attend Workgroup meetings, and while the Best Practices document has been drafted it has not yet been distributed to all the hospitals. The hospitals are not being monitored to determine whether they are implementing the best practices that are discussed in these meetings. The best practices discussed in the meetings all required money (or employee-hours) to implement, and the County of San Diego is not funding any new programs to implement these practices. While the Workgroup meetings are undoubtedly beneficial in generating discussion and spreading ideas, it is possible that other factors besides these meetings could be additional influences in helping to drive the readmission numbers down. For example, the Affordable Care Act requires the Centers for

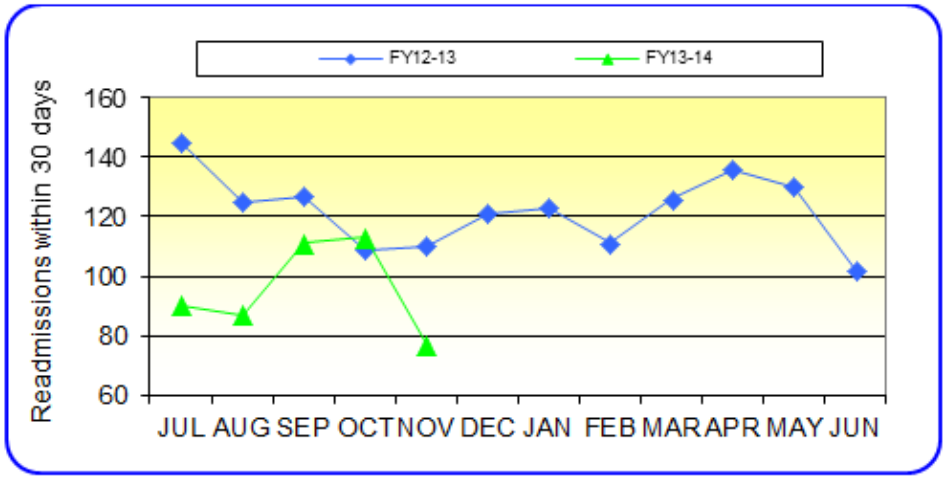
Medicare & Medicaid Services to levy fines against hospitals whose readmissions rates are deemed too high (source: American Hospital Association. Factsheet: Hospital Readmission Reduction Program. April 18, 2013.)

Present objective data results for each performance indicator. Use Table D and attach supporting data as tables, charts, or graphs.
Include the raw numbers that serve as numerator and denominator!

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
(A/OA) – Readmissions within 30 days @ FFS Hospitals	June - November 2012	123.2 monthly mean over the period of June 2012 – November 2012 (739 readmissions divided by 6 months)	10%	Readmissions Workgroup meets to discuss best practices in reducing readmissions	June - November 2013	96.7 monthly mean for June – November 2013 (580 readmissions divided by 6 months)	22.5%

(A/OA) – READMISSIONS WITHIN 30 DAYS @ FFS HOSPITALS



Current Trends:
November '13 vs November '12 ..... - 30.00% (77 vs 110 clients)
November '13 vs October '13 ..... - 31.83% (77 vs 113 clients)

Annual Trends:
YTD13-14 Mean ..... 96 YTD13-14 Total 478
FY12-13 Mean ..... 122 FY12-13 Total 1,465

Trend Analysis:
The number of readmissions for November '13 decreased from October '13.

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur. Provide explanation for any analysis occurring less frequently than quarterly. Some activities and outcomes benefit from or require close, routine monitoring.

Monthly data is used.

b. Statistical significance

A paired samples t-test reveals $p = 0.024$, indicating statistical significance.

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	JunetoNov2012	96.6667	6	14.32015	5.84618
	JunetoNov2013	123.1667	6	13.18206	5.38155

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	JunetoNov2012 & JunetoNov2013	6	-.087	.871

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	JunetoNov2012 - JunetoNov2013	-26.50000	20.28546	8.28151	-47.78829	-5.21171	-3.200	5	.024

c. Are there any factors that influence comparability of the initial and repeat measures?

No.

d. Are there any factors that threaten the internal or the external validity?

No.

18. To what extent was the PIP successful? Describe any follow-up activities and their success.

1. The PIP was successful in that the number of readmissions for the measured period of time fell by 22.5%, which is more than double the goal of reducing readmissions by 10%.
2. The PIP was successful in that the difference between the measured period of June to November 2013 and the baseline period of June to November 2012 reached the threshold of statistical significance of $p < .05$. It should be noted that it is very difficult to achieve statistical significance with such a small *N* (six months), and that it is impressive that statistical significance was achieved with a *p* value of .024.
3. It would be ideal if the readmissions rates and other measures can continue to be tracked for several more years in order to more fully measure the performance of this PIP. The work of disseminating information about best practices is still in progress, and so the amount of data that is available so far is just the "tip of the iceberg" in measuring the success of these interventions.
4. The Readmissions Core Workgroup continues to disseminate information about best practices in reducing readmissions to the key stakeholders.
5. OptumHealth will continue to provide reports of readmission data to individual hospitals for monitoring.
6. The Hope Connections program is looking to modify its program to continue providing services within the System of Care. Hope Connections was originally funded through MHSA's Innovation component for new programs.
7. OptumHealth releases a quarterly report called CO-20 with quarterly data regarding connection to services post-discharge. Stakeholders within the System of Care will continue to monitor this measure in order to identify trends.

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

(A/OA) – Readmissions within 30 days @ FFS Hospitals was the measurement used both at baseline (June – November 2012) and the measurement period (June – November 2013). No modifications were made. Baseline was set for the same months of the previous year so as to avoid seasonal effects.

20. Does data analysis demonstrate an improvement in processes or client outcomes?

Yes, data analysis demonstrated a reduction in readmissions, which demonstrated an improvement in processes (reducing readmissions) and allows us to infer an improvement in client outcomes (an improvement in clients being able to get needed care without being readmitted).

21. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

Face validity is a term used to describe whether a test, measurement, or statistic measures the concept that is supposed to be measured. The concept that is supposed to be measured is readmissions after discharge from psychiatric care. The measure "(A/OA) – Readmissions within 30 days @ FFS Hospitals," taken from the MHB Dashboard, has high face validity because it is a measure that closely matches the concept. It appears that the improvement in this measure is the result of the Hospital Readmissions Workgroup beginning to meet and focus on the issue, because the month after meetings began the measure fell 21.54%, and the measure was 22.5% lower than baseline over the six month span beginning the month after meetings began. It is unlikely that this improvement occurred due to chance.

22. Describe statistical evidence that supports that the improvement is true improvement.

A paired samples t-test showed that the improvement was statistically significant to a *p* value of .024. This means that there is only a 2.4% chance of a false positive – that the change in the figures was due to chance rather than true improvement. $P < .05$ is the standard for statistical significance that is used by social scientists, and the improvement in readmissions figures meets these standards.

23. Was the improvement sustained over repeated measurements over comparable time periods? Or, what is the plan for monitoring and sustaining improvement?

The improvement was sustained over a period of six months – up to the most current data available on the Mental Health Board Dashboard. This improvement is as compared to a baseline of the same months of the previous year. The improvement will continue to be monitored because the measure of "(A/OA) – Readmissions within 30 days @ FFS Hospitals" is published monthly on the Mental Health Board Dashboard, which is distributed at the monthly Mental Health Board meeting which is attended by key stakeholders. The Hospital Readmissions Core Workgroup members continue to communicate regarding readmissions, and will meet or hold larger meetings that key stakeholders are invited to as necessary in order to sustain improvement in addressing the issue of readmissions.

List of Attachments:

Attachment A: Readmission Article Summary and Presentation Review Grid.
Attachment B: "Reducing Hospital Readmissions" report on 14 clients who are high utilizers of inpatient services.
Attachment C: "Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders"
Attachment D: Readmission Workgroup Themes
Attachment E: "Best Practices – Commonalities through Multiple Programs That Help Clients with Connection to Services" draft
Attachment F: FFS Inpatient Psychiatric Summary Readmission Rates
Attachment G: Medi-Cal Readmission Client Data Report

Reducing Hospital Readmission Article and Presentation Review

	Program Description	Outcomes	Highlights, Key Findings & Barriers Identified
Peer Bridger Program *(Source: OptumHealth Peer Bridgers)*	Supported 125 individuals in its initial cohort. Assists adults during the transition period following discharge from inpatient psychiatric care. Many of the participants have histories of multiple psychiatric hospitalizations, homelessness, and unemployment.	In one year after discharge, 79% reduction in overall hospitalizations. $4,400 savings/person enrolled.	Support from peers with lived experience. Savings and positive impact for a full year -- not just in month following discharge.
Preventable Readmissions Network (PRN) *(Source: Draft Project Charter for Preventable Readmissions through Networking (PRN), January 2011)*	Charter of a plan to decrease readmissions through helping participants with transition after discharge. Focus on the 20% of readmissions within 30 days of discharge that are possibly preventable. Focus on high-risk groups: multiple comorbidities. Not behavioral health-specific.	N/A	None
Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders *[Source: Reducing Avoidable Readmissions Effectively (RARE)]*	This document addresses five key areas in which to improve quality, that will have an effect on avoidable readmissions: 1) Patient-Family Engagement and Activation; 2) Medication Management; 3) Comprehensive Transition Planning; 4) Care Transitions Support; 5) Transition Communication.	N/A	If lack of family support system - suggests using a surrogate like a case manager. Make sure instructions are understood – suggests using Teach-Back method to check for comprehension. Medication issues like benefit coverage/affordability, and reconciliation with other meds.
Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use *(Source: America's Health Insurance Plans Center for Policy and Research)*	This document gives profiles of numerous programs aimed at reducing hospital admissions, readmissions, and emergency room use. One program addresses readmissions to psychiatric hospitals.	Participating psychiatric hospitals had readmission rate fall from 17.7% to 14.9%.	The program focuses more on having quarterly meetings between Amerigroup and psychiatric hospital staff – rather than on making contact with discharged patients like in the Peer Bridger Program. This program focuses on identifying factors that can lead to readmission, such as: length of stay too short, lack of timely follow-up visit with BH practitioner, difficulties with medications, substance abuse.
San Diego Care Transitions Partnership *(Source: http://calhospital.s1017.sureserver.com/sites/main/files/fileattachments/san_diego_lan_presentation_final_031413.pdf)*	This document has several PowerPoint presentations describing CTI pilot programs implemented by San Diego hospitals. SDCTP (San Diego Care Transitions Partnership) is a partnership of 11 hospitals with 13 campuses.	Decrease LOS, Readmissions, Admissions from ED; Increase patient, doctor and staff satisfaction. No figures are given.	Many similarities between the various programs at different hospitals. A CTI coach works with individuals after discharge. Focuses on four pillars: medication management, patient centered record, physician follow-up, knowledge of red flags. None of the programs were specifically focused on behavioral health issues.

	Program Description	Outcomes	Highlights, Key Findings & Barriers Identified
LIHP *(Source: Kristie Tokar – Optum Health)*	Low Income Health Program (133% poverty level and below): Began 2011. Mission: Integrate physical & behavioral health and social services; streamline access to right care; improve cost efficiencies. Benefits include medical services and case management (health coaching, education on benefits, intent to empower client)	LIHP Actively Case Managed population had readmission rate at least 50% lower than the similar populations that didn't receive this benefit.	A regional field-based approach, and strength-based recovery, are effective. Need for flexibility and diversity in services, and quality improvement and oversight. It is a challenge to keep homeless population engaged in care.
Beacon Care Transitions **(***Source: Brenda Schmitthenner – AIS)*	For four weeks after discharge for BH issue, patients work with a coach – one home visit and two phone consults. Support with self-management skills, medication management, and scheduling follow-up appointments with doctors.	Readmissions rate lower than SMH average within 30 days (2.3% vs 12.6%), 60 days (5.7% vs 17%), 90 days (8% vs. 24.3%). Estimated savings of $303,342 for 298 CTI program completers.	CTI can succeed with indigent, medically and socially complex patients. Patient-centered approach. Positive results from four-week intervention can last as far out as 90 days (and, most likely, further). The coaches succeed because they know how to connect and collaborate with and listen to patients.
SHARI *(Source: Joyce Thompson & David Armstrong – Optum Health)*	Special Help for At-Risk Individuals. From '04-'11, served ~ 25-30 clients who are at risk of suicide. Client-centered treatment, encouraging treatment compliance, coping strategies. For continuity of care, clients assigned a designated START facility, FFS hospital, and attending doctor. One Case Manager assigned to client who helps them get to the appropriate services. EPU is gateway for clients to access services.	FFS hospital days dropped by 763 (92%) from baseline to one year, crisis house days dropped by 29 (19%), IMD days dropped to zero, EPU contacts increased by 84 (300%).	Client benefits included: better med compliance, more involvement w/clubhouse activity, regaining visitation rights w/child. Benefit of having written notes saying what techniques help and don't help client during times of stress. Clinicians involved in SHARI made high-risk decisions daily because clients had histories of suicidal behavior. Challenges arose with continuity of care because of doctors' shift schedules at hospitals.
Telecare Transition Team	Provides short-term Case Management services for at-risk uninsured or Medi-Cal individuals on BHU or recently discharged. Links clients to BH services, and goes with them to the appointments.	Increase in # of clients accessing crisis residential, SDCPH, and outpatient services; decrease in # of clients accessing emergency, FFS outpatient, hospital, and jail. 53% decrease in hospital readmissions from six months pre-connection to six months post.	Importance of making sure clients can get outpatient BH services appointments within necessary timeframe after discharge, and get to those appointments. Going to appointment with client ensures they get to their appointment. Importance of ensuring clients can get access to needed medication.
Hope Connections	An MHSA Innovations program giving peer support and family engagement to clients and families in: SD County's EPU, SDCPH, and designated OP clinics. Support staff (peer & family specialists, and RNs and licensed clinicians) offer referrals, coaching, links to BH services, help navigating BH and health care systems, employment, socialization. Goals to boost client independence and decision-making and decrease stigma.	Individuals contacted/enrolled had a decrease in EPU services, PERT services, and inpatient hospital services, and an increase in OP and Crisis Residential services. Hospital readmission rates were not much different vs the comparison group. For first six months of the program, savings estimated at $401K for enrolled and $1.345 M for contact group, for a total of $1.75M.	There was an improvement in service utilization trends not only among individuals enrolled in the program, but also in those who had contact with Hope staff but were not enrolled. There was a cost savings of $1,526 per contacted individual ($3,612 savings per enrolled individual). Helped shift clients' service utilization from a crisis-based to a recovery-based method. Giving cellphones to clients helped to maintain contact, overcoming barrier of difficulty maintaining contact with homeless clients.
Bridge to Recovery	MHSA-funded PEI for underfunded & uninsured patients w/substance abuse disorders who come to SDCPH. SBIRT model: Screening, Brief Intervention, and Referral to Treatment. 90-day Case Management to engage, stabilize, and build bridge for client to utilize services. Prepare client to fully engage in treatment through: basic needs, stabilization, building skills, increasing motivation, providing caring support. 30-33% of clients are homeless.	Little data available yet on outcomes. Readmission rates to SDCPH range from 2%-4% per quarter. Of 4,465 unduplicated clients, only two have completed suicide attempts.	Harm reduction model (meet clients where they are at). Motivational interviewing to help clients move to next stage of change. Providing onsite support at residential treatment centers to reduce client dropout rate. Meeting with clients while they are on the waiting list for services. Multiple visits at SDCPH. BTR has faced problem-solving limitations in collecting data. Recommendations: incorporate BTR to have greater access to County data, and allowing computer system at SDCPH to indicate clients referred to BTR to make readmission referral process smoother.

Attachment B: Reducing Hospital Readmissions

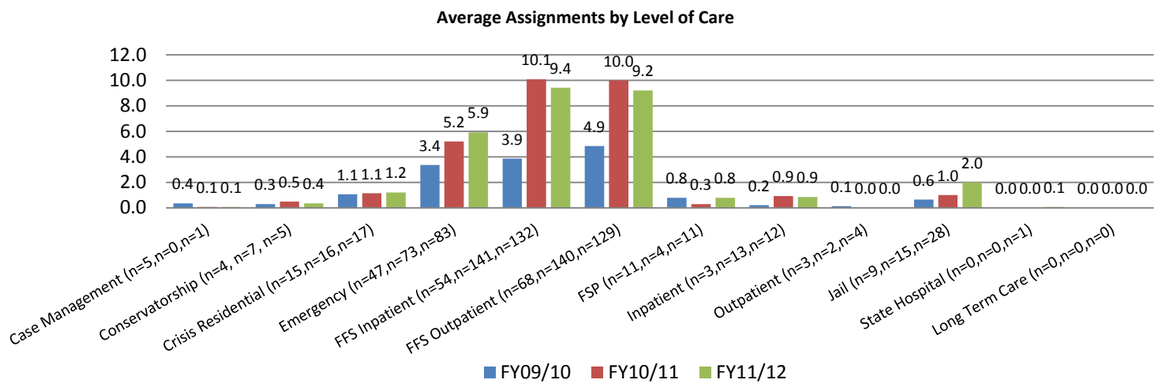
Incarceration

(Based on Jail Assignments in Anasazi)

	Min Days	Max Days	Total Jail Days	Average Days Per Client	# of Clients with at least 1 Jail Assignment	# of Assignments	Average Assignments Per Client
FY09/10	0	36	69	11.5	6	9	1.5
FY10/11	0	121	159	19.9	8	14	1.8
FY11/12	0	96	333	37.0	9	28	3.1

There were 9 Jail assignments in FY09/10, 14 in FY 10/11, and 28 in FY11/12, for a total of 51 in all 3 years combined. In FY09/10 the total Length of Stay (LOS) for all clients combined was 69 days, in FY 10/11 the total was 159 days, and in FY11/12 the total was 333 days, for a total of 561 days combined. In FY 09/10 there were 6 clients who had at least one Jail assignment. On average each client had 1.5 Jail assignments in FY09/10. In FY10/11 there were 8 clients who had at least one Jail assignment. On average each client had 1.75 Jail assignments in FY10/11. In FY11/12 there were 9 clients who had at least one Jail assignment. On average each client had 3.1 Jail assignments in FY11/12. The range of days for FY09/10, FY10/11, and FY11/12 were 0 - 36, 0 - 121, and 0 - 96 days

Level of Care Assignments



FFS Outpatient Data - Assignments

In FY09/10-FY11/12 there were 337 Outpatient Service Assignments. Each of the 14 clients had at least 16 assignments, with a range of 16 assignments to 42 assignments.

FFS Outpatient Data - Services

In FY09/10-FY11/12 there were 2519 Outpatient Services. Each of the 14 clients had at least 56 services, with a range of 56 outpatient services to 350 outpatient services.

FFS Outpatient Data – Providers

In FY09/10-FY11/12 five FFS Outpatient Providers completed 78% of the total services, and on average saw 9.4 unique clients.

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5
Services	662	594	411	154	145
Unique Clients	14	11	10	4	8

FFS Outpatient Data – Clients

Each of the clients saw at least 4 different FFS Outpatient Providers between FY09/10-FY11/12. The client who saw the most providers was Client 4, who saw 18 different providers.

	Client 1	Client 2	Client 3	Client 4	Client 5	Client 6	Client 7	Client 8	Client 9	Client 10	Client 11	Client 12	Client 13	Client 14
Number of FFS Outpatient Providers Seen	4	5	11	18	12	7	13	10	13	10	8	12	8	10

Reducing Hospital Readmissions

Population with 4+ Readmissions in both FY10/11 and FY11/12 (14 High Utilizer Clients)	%	n
Gender		
Female	50%	7
Male	50%	7
Age		
Minimum	22 years	
Maximum	55 years	
Mean	38.5 years	
Race/Ethnicity		
White	29%	4
Hispanic	29%	4
African American	21%	3
Asian Pacific/Islander	7%	1
Mixed/Other	14%	2
Primary Diagnosis		
Schiz. Disorder	50%	7
Mood Disorder	22%	3
Bipolar Disorder	22%	3
Psychotic Disorder	6%	1
Substance Abuse Diagnosis		
Yes	100%	14
No	0%	0
Admissions to Jail (Based on Jail Assignments)		
0 times	14%	2
1-2 times	36%	5
3-4 times	21%	3
5 or more times	29%	4
Employment Status		
Not in Labor Force +	43%	6
Unemployed, Not seeking work ◊	57%	8

+ Not currently working, nor actively seeking work
◊ Children under 18 who are not a student and not working or seeking work; and Disabled Adults who are not seeking employment

Total Inpatient Admissions

Inpatient Admits by Fiscal Year			
	Range		
	Min	Max	Mean
FY09/10	0	11	4 admits
FY10/11	6	18	10 admits
FY11/12	4	16	10 admits

In FY09/10 the range of Inpatient admissions was 0 to 11 admissions per client, with an average of 4 admissions. In FY10/11 there was a range of 6 to 18 admissions per client, with an average of 10 admissions, an increase from prior year. In FY 11/12 there was a range of 4 to 16 admissions per client, with an average of 10 admissions, which remained constant compared to prior year.

County Inpatient Admit: In FY09/10 the range of County Inpatient admits was 0 admits to 3 admits per client, with an average of 0.21 admits. In FY10/11 there was a range of 0 admits to 9 admits per client, with an average of 0.93 admits, an increase from prior year. In FY 11/12 there was a range of 0 admits to 3 admits per client, with an average of 0.86 admits, a decrease from prior year.

FFS Inpatient Length of Stay

FFS Inpatient LOS by Fiscal Year			
	Range		
	Min	Max	Mean
09/10	1	48	9.14 days
10/11	1	45	7.33 days
11/12	1	75	7.23 days

In FY09/10 the range of length of stay for FFS Inpatient was 1 day to 48 days, with an average of 9.14 days per inpatient stay. In FY10/11 the range of length of stay was 1 day to 45 days, with an average of 7.33 days per inpatient stay, a decrease from prior year. In FY11/12 the range length of stay was 1 day to 75 days, with an average of 7.23 days per inpatient stay, a slight decrease from prior year.

County Inpatient Length of Stay

County Inpatient LOS by Fiscal Year			
	Range		
	Min	Max	Mean
09/10	1	128	58.33 days
10/11	1	74	19.85 days
11/12	1	152	25.25 days

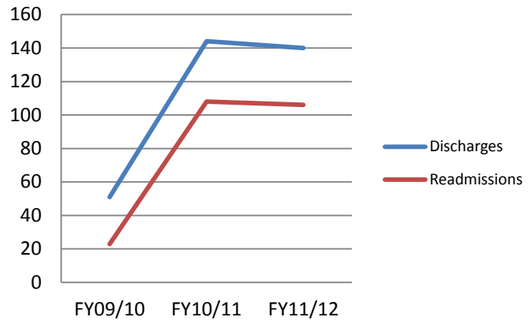
In FY09/10 the range of length of stay for County Inpatient was 1 day to 128 days, with an average of 58.33 days per inpatient stay. In FY10/11 the range of length of stay was 1 day to 74 days, with an average of 19.85 days per inpatient stay, a decrease from prior year. In FY11/12 the range of length of stay was 1 day to 125 days, with an average of 25.25 days per inpatient stay, an increase from prior year.

Comparison of Hospitals by Discharge and Readmissions

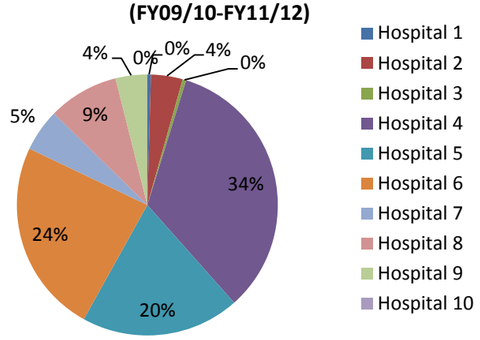
Fiscal Year 09/10 – Fiscal Year 11/12					
	Discharges	Total Readmissions	Readmissions- Same Facility	Readmissions - Different Facility	Readmits - Different System (BHS to FFS or FFS to BHS)
Hospital 1	1	1	0	1	0
Hospital 2	10	9	0	9	9
Hospital 3	2	1	0	1	0
Hospital 4	106	77	31	46	3
Hospital 5	58	45	8	37	2
Hospital 6	91	55	21	34	1
Hospital 7	15	12	4	8	2
Hospital 8	26	20	5	15	1
Hospital 9	10	9	3	6	0
Hospital 10	18	8	1	7	0
Total	**337**	**237**	**73**	**164**	**18**

* Readmission is classified as a discharge and an admission within a 30 day period

Hosptal Discharges and Readmissions



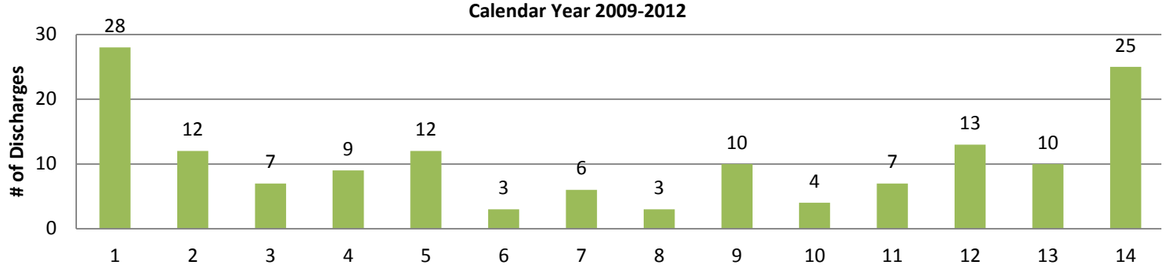
Total Readmissions By Hospital (FY09/10-FY11/12)



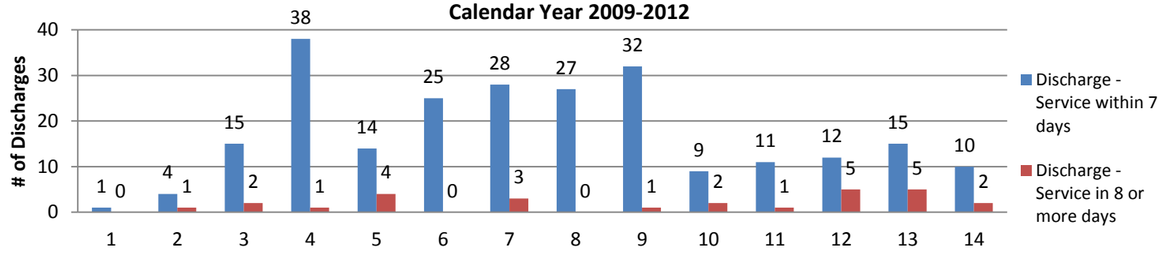
*For Calendar Years 2009-2012 the distribution and trends mirror the data that is presented above for FY09/10-FY11/12

Total Hospital Discharges by Client – Calendar Year 2009- 2012														
Client	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Discharges	29	17	24	48	40	28	37	30	43	15	19	30	30	37

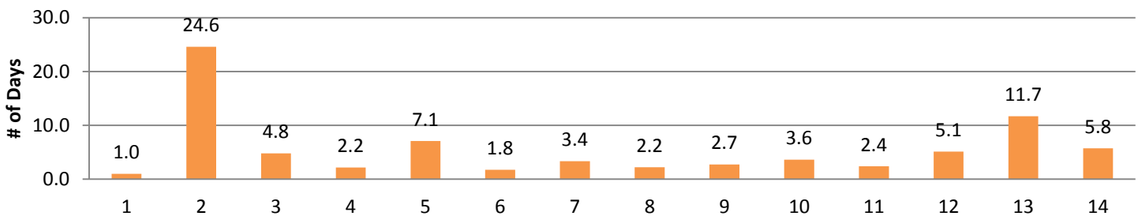
Number of Discharges with No Services Between Hospitalizations by Client Calendar Year 2009-2012



Time Between Discharge and 1st Contact by Client Calendar Year 2009-2012



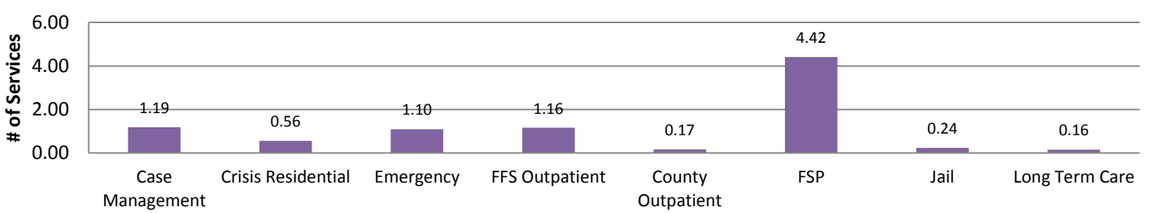
Average Days Before 1st Service After Hospitalization Discharge by Client* Calendar Year 2009-2012



*Client 2 – 106 day outlier, Client 5 – 50 day outlier, Client 12 – 22 day outlier, Client 13- 68, 26, and 83 day outliers, Client 14 – 32 day outlier

Average Days Between 1st Service and 2nd Service After Hospitalization Discharge by Client Calendar Year 2009-2012

Average Services Received Prior to Hospitalization



Averages for All 14 Clients : Calendar Year 2009-2012				
Number of Discharges with No Services Between Hospitalizations	1st service less than or equal to 7 days after discharge	1st services greater than 7 days after discharge	Average Days Before 1st Service	Average Days Between 1st Service and 2nd Service
10.6	17.2	1.9	4.38	3.89

RARE
Reducing Avoidable
Readmissions Effectively

Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders

The transition period between care settings is the most vulnerable time for patients and their caregivers. The unique vulnerabilities for patients with mental illnesses such as depression, mania, anxiety, schizophrenia and/or substance use disorders* heighten the need for coordinated transitions and aftercare. In 2010, depression was the fourth diagnosis by volume for readmissions in Minnesota according to the Potentially Preventable Readmissions data collected by the Minnesota Hospital Association.

This document is intended for health care professionals who provide care for patients in a variety of settings. It provides basic recommendations in five key areas that are well-recognized core strategies for care transition improvement along with recommendations specific to mental health populations. These recommendations based on best practices, evidence and consensus are key practices that organizations should be working to implement. Additionally, this document identifies key recommendations that are important specifically for care transitions improvement when working with patients with new or existing mental illnesses. This document does not specifically focus on delirium or dementia but many of the recommendations will also help support the families of these patients.

This document is aimed at three types of mental health patient populations:

1. Inpatient mental health admissions and readmissions.
2. Patients who are admitted to acute care hospitals for medical/surgical conditions who also have a mental illness and/or substance use disorder.
3. Patients with acute or exacerbation of chronic medical illnesses who subsequently develop a mental illness, such as depression with congestive heart failure or anxiety with chronic obstructive pulmonary disease (COPD).

The RARE Campaign was established to focus efforts across the state to improve the quality of care for patients transitioning across care systems and to reduce avoidable readmissions by 20% by the end of 2012. For our patients this means 16,000 nights of sleep at home rather than in a hospital bed.

In preparing this document, a group of dedicated mental health stakeholders assembled to engage in dialogue regarding opportunities to improve care transitions for these patients. In addition to completing a literature review, the work group identified aspects associated with care of some mental health patients that can further challenge care transitions such as stigma associated with mental illnesses; siloed and fragmented care; barriers to involving family and/or friends; transportation challenges; health care access limitations; and medication complexities. The literature in the area of care transitions in mental health is a limited but developing body of evidence and it was used where applicable; however, many of the recommendations put forth were based on experience, organizational pilots, promising practices and group consensus.

A companion document *Recommended Actions for Improved Care Transitions* is available on the RARE website, along with comprehensive information about the RARE Campaign and other interventions to reduce avoidable readmissions.

www.RAREreadmissions.org

*Throughout this document, when the term mental illness is mentioned, it also includes substance use disorders.

Table of Contents

The RARE Campaign calls upon hospitals and their partners along the care continuum to focus on five key areas known to improve care and thereby reduce avoidable hospital readmissions.

The Five Key Areas

The issues that influence avoidable readmissions are many and complex. Improvement work needs to be done in each care setting and across care settings to make an impact. In analyzing the literature, local and national programs, five areas have been identified as a focus for quality improvement efforts.

#1 Patient/Family Engagement and Activation

#2 Medication Management

#3 Comprehensive Transition Planning

#4 Care Transition Support

#5 Transition Communication

#1 Patient/Family Engagement and Activation

In our culture, many patients and their families have been relegated to a passive role in their health care. Rather than assisting in developing a realistic plan for care outside the hospital, they may simply be told the plan, which may not be workable for the patient or the family. They may also feel powerless to bring up issues with health care professionals. In the case of mental illnesses, the family can be marginalized in their involvement for many reasons including misunderstood or misapplied privacy policies.

In this document we will use the term family with the understanding that the patient defines "family." Friends rather than relatives may be the patient's family in terms of support. Patients and families have wide variation in their knowledge of the health care system and their understanding of the issues that affect them. Hospitalized patients may be impaired by their illness, pain, and sedatives or simply confused by what they are experiencing. These factors, along with cultural and language issues, may prevent patients from being fully engaged in their health care and decision-making processes.

The patient and their family live daily with their condition and they need to be as engaged as possible as they make numerous decisions about their care, often in the absence of any guidance by health care professionals. Families are often an unrecognized resource in providing safe transitions for patients. Organizations working to improve in this area focus on ensuring that processes are in place to engage patients and their family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. (Coleman, 2011)

Recommendations for All Patients:

- Ask the patient to identify family and friends who comprise their support network. HIPAA does assume consent if the patient allows the family and friends to be present during discussions.

- Care team members are strongly encouraged to involve family in the treatment process upon admission, potentially including participating in Emergency Department evaluation, admission intake assessments and engagement of outpatient providers. Families should be invited and highly encouraged to participate in establishing the goals and plan of care, offering feedback throughout treatment, and developing the discharge plan. Consideration should be given to type, intensity and setting of care needed for the successful treatment of the patient with consideration of family involvement.
- Care team members are strongly encouraged to use the Teach Back method to assess comprehension of instructions given to the patient and family during and after transitions, including general and disease-specific information. Care providers should include family whenever possible. If Teach Back is unsuccessful or the patient is unable to perform all requirements of the care plan, the plan needs to be modified. This may be accomplished by engaging family to assist in carrying out the plan with the patient. (Project BOOST)
- Care providers must utilize health literacy standards such as the AHRQ Health Literacy Universal Precautions Toolkit to ensure that spoken language and written materials are easy to understand from the patient's and family's perspective. (DeWalt, 2010)

Recommendations for Patients with Mental Illnesses:

- Proactively obtain releases of information to include family members at each appropriate interaction. Obtain appropriate releases to engage these people in the care, planning and transition early in the hospital stay. Some inpatients on mental health units may be reluctant at first, but may be more open later in their stay to having family involved.
- Care teams are strongly encouraged to be knowledgeable of and make frequent referrals to community support services, including:
  - Mental health and/or chemical health support groups
  - Social services available through a variety of county and charitable organizations, including:
    - Financial assistance for medications
    - Transportation assistance
    - Nutritional support
    - Emergency housing
    - Assistance services such as homemaker services and behavioral aide support
    - Supported leisure options
    - Volunteering opportunities
- If the patient does not have a family support system, include a surrogate such as a Case Manager or Assertive Community Treatment (ACT) team member.

#2 Medication Management

Medications are important components of an overall strategy to manage complex acute and chronic conditions. However, the number and complexity of medication regimes and medical jargon may leave the patient and their caregivers in a quandary as to how to follow so many instructions. They may also experience difficulty in obtaining medications due to financial constraints. Patients and caregivers need support in how they can become active managers of their medication regimes, including why, how and when to take the medications. Additional improvement opportunities exist to ensure patients are prescribed only what they need and that the benefits of those medications outweigh the risks.

Recommendations for All Patients:

- Medication Reconciliation

  Medication reconciliation must be completed at each patient transition, not just as a completed task, but also as a means to ensure safety, accuracy and appropriateness of medication therapy, and to facilitate communication and shared understanding between the care team and the patient. Remember to ask about over-the-counter (OTC) medications, vitamins, herbals, other non-prescription supplements and about substance use, if any. This should be addressed with the patient and family along with outpatient primary care and behavioral health providers as part of comprehensive transition planning. (NPSG 03.06.01 TJC)

• Patient Medication List

Reconciled medication lists should indicate the purpose of each medication and the date of completed reconciliation. Any identified discrepancies must be evaluated and resolved. (NPSG 02.06.01 TJC)

Optimal elements in the medication list include:

- Name of the medication
- Purpose of the medication
- Side effects
- How to take the medication
- When to take the medication
- Future anticipated dosage changes, e.g. titrating doses
- Current changes in the medication regime
- Formulary availability, cost and generic alternatives
- Possible interactions with other medications and substances such as alcohol and food

• Medication Availability

Recognizing that medication prescribing in acute care organizations may be influenced by hospital formulary requirements, it is strongly suggested that in order to avoid unnecessary disruptions/changes in medication therapy regimes, items such as benefit coverage and affordability be discussed with the patient and family and that they be engaged in shared decision-making around medication therapy.

• Patient Agreement and Understanding

When transitioning out of the hospital, the patient should be engaged in their plan for medications and agreement to follow that plan should be assured. Changes in the medication regime from pre-hospital medications should be made clear to the patient and family, including guidance on OTC medications and use of substances such as alcohol. Ask the patient and the family what medications are in the home and discuss the plan for their use or disposal. Teach Back is an effective strategy that should be used to elicit the level of understanding needed by the patient and family to take medications safely and as prescribed. (Project BOOST)

Recommendations for Patients with Mental Illnesses:

• Quantity of Medications

Condition-specific consideration should be given when ordering medication supply. For example, if the patient has had suicidal issues or major depression in the past, quantities of potentially lethal medications should be limited.

• Communication of Medication Plans

Acknowledging the complexities associated with medication therapy for mental illnesses such as required medication titration, it is imperative that the communication regarding intended plans for medications be clear to all providers caring for the patient as well as the patient and family.

• Screen For Other Co-occurring Disorders

Screen at-risk psychiatric and medical patients with such issues as trauma, stroke, myocardial infarction, cancer and diabetes, for possible substance use disorder. When warranted, use motivational interviewing methods.

• Special Population Considerations

Special considerations should be given for patients who are:

- Incapacitated with respect to medical decision-making or have been deemed legally incompetent
- Confused or experiencing cognitive deficits
- On involuntary commitment
- In the midst of acute psychotic episodes
- Newly diagnosed
- Live alone without support
- Experiencing cognitive deficits

For these patients, consider strategies to enhance adherence such as:

- Direct observation of medication use
- Depot medications – a special formulation of the medication that is given by injection and gradually released into the body over a period of time
- Involvement of a case/care manager

Other Possible Strategies:

- Medication Therapy Management should be offered in the acute and ambulatory care settings for patients who have special challenges.
- A pharmacist should review orders at the time of transition for accuracy and necessity, potential side effects and/or interactions for high-risk patients. (Frandzel, 2012)
- For high-risk patients, consider offering a structured follow-up visit, either by phone or home visit, to reconcile the medication list with what the patient is actually taking. Consider OTC, legal and illegal substances.

#3 Comprehensive Transition Planning

The comprehensive transition plan (formerly called discharge instructions) is a guide developed collaboratively between the discharging care team and the patient and family for the tasks that are to be done by the patient and family post-hospitalization. The focus is to ensure that all of a patient's needs are considered and the information is delivered in a way that the patient and family can understand and use as a reference. Consideration should be given to any identified cognitive deficits as well as literacy and health literacy in preparing these materials. (Sheppard, 2010) (Project RED)

Recommendations for All Patients:

A written patient-centered transition plan must include the following:

- Reason for hospitalization, including information on diagnosis in terms the patient and family can understand
- Medications to be taken post-transition, including, as appropriate, resumption of pre-admission medications:
  - Purpose of medication
  - Dosage of medication
  - When to take medication
  - How to take medication
  - How to obtain medication and refills
  - Where to obtain medications
  - Instructions regarding OTC, legal and illegal substances considering the patient's prior history
- Self-care activities such as exercise and diet
- Crisis Management: Condition-specific symptom recognition and management, including:
  - Symptoms that warrant a patient response and understanding action steps and what care options are available (red flags)
  - What to do if a red flag occurs, including the urgency of the issue, who to contact, how to contact them, and what to do in an emergency and after clinic hours
- Coordination and planning for follow-up appointments
  - Appointments should be made prior to transition and usually within seven business days of transition (based on the patient's condition)
  - Involves coordination with the patient and family to ensure they will be able to get to and keep the appointment
- The transition plan must be written in easy-to-understand, plain language, using only as many words as necessary, meeting as many health literacy standards as possible. Also avoid medical jargon, abbreviations and acronyms. Teach Back may also be useful in this regard.

Recommendations for Patients with Mental Illnesses:

The transitional care plan should also include the following:

- Coping Skills
  - Sleep hygiene
  - Self-soothing
- Nutrition/Exercise
  - Diet
  - Physical activity level or limitations
  - Weight monitoring
  - Yoga, meditation
- Recovery Goal/Plan
  - Work
  - Social
  - Harm reduction
  - School
- For patients with acute or chronic medical conditions and newly diagnosed depression or anxiety, a follow-up appointment with a mental health provider in addition to their primary care provider.

- If there are physical health considerations and the patient does not have a primary care physician or clinic, help the patient obtain one for physical health issues and preventative care. Note: Research has shown that disregarding the preventive and physical needs of a mentally ill patient can put them in danger of earlier occurrence of chronic diseases. (MN 10x10)

  The following should be addressed in the primary care follow-up:
  - Preventive measures such as immunizations
  - Orientation to long-term health and lifestyle issues
  - Frequency of follow-up needed
  - Patient goals for overall health such as tobacco cessation, exercise, weight loss, etc.
  - Provide brochures, websites or phone numbers for information on topics most pertinent to the individual patient

#4 Care Transition Support

The transition period between care settings is the most vulnerable time for patients and their families. Fragmentation in the health care system often leaves the patient to navigate a complicated system without adequate knowledge and support. The objective of care transition support is to help the patient and family successfully transition from one care provider to the next.

Recommendations for Patients with Mental Illnesses:

Post-hospitalization follow-up:

- The patient should have a follow-up appointment with a provider of mental health services within seven calendar days post-hospitalization or sooner if their condition warrants, to review their progress and plan of care.
- For new referrals, facilitate the connection between the patient and the agency to which the patient is being referred to ensure a successful connection.
- The receiving mental health provider should have a system to accommodate availability for transitioned patients within seven calendar days.
- All patients with mental illnesses and chronic or acute physical problems should have an appointment scheduled with their medical provider prior to discharge from the hospital.
- An adult mental health patient who does not have a designated primary care provider should be connected to one and an appointment made within 60 days for a physical assessment and prevention interventions..
- Within 72 hours of transition, a team member with knowledge of the patient's history and plan of care should contact the patient to review the care transition plan (including medication and possible medication side-effects) and inquire as to any questions or new concerns.
- Teach Back and open-ended questions should be used to assess and ensure the patient and family understands and is able and willing to follow through on the plan of care, including attending follow-up appointments.
- Brief teaching of the patient (and family if applicable) on the content of the follow-up visit should focus on preparation, including:
  - Patient's goals for the visit, factors contributing to admission or emergency department visit and current medication regime
  - Patient's need for medication adjustment, follow-up on outstanding test results, monitoring and testing, psychosocial environmental factors, and instruction on self-management using Teach Back
  - Patient and family questions regarding warning signs and how to respond using Teach Back
  - Review crisis plan and ensure it continues to meet the needs of the patient.
  - Ask about any changes in the patient's living situation, including temporary or permanent changes in address, access to transportation or any previously unidentified concerns
  - Expect questions regarding why and how the patient's medical problems are being managed
  - Expect questions about OTC medications, vitamins, herbs, supplements, and legal or illegal substance use or abuse.
  - Expect questions about healthy lifestyle choices and support

Other Strategies:

- Care Transitions Intervention®. This intervention developed by Dr. Eric Coleman and his team at the University of Colorado uses a coach to support the patient through their transition. The coach focuses on helping the

patient and family caregiver develop skills and confidence to assert their treatment preferences and ensure that their needs are being met during transitions. It is recommended that the coach have a mental health background when providing coaching for a mental health patient. www.caretransitions.org (Coleman, 2006)

- Case or care managers have a series of regular follow-up communications with the patient to ensure that medications, meals/nutrition, transportation, appointments and other needs of the patient are in place.
- Consider an Assertive Community Treatment intervention (ACT), a service-delivery model that provides comprehensive, locally-based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year. (http://www.namihelps.org/assets/PDFs/fact-sheets/General/Assertive-Community-Treatment.pdf)
- Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness and other adverse outcomes in people with mental illnesses following discharge from hospitals, shelters, prisons and other institutions. (http://www.criticaltime.org/model-detail/)

#5 Transition Communication

Lack of timely and adequate information between providers and sites of care contributes to discontinuity of care and the risk of readmissions for patients. Transition information may be too late, too much, not enough, or in a format that renders it suboptimal or even unusable.

Recommendations for All Patients:

- The patient's providers, including mental health, primary care, specialists and others, should be notified as soon as possible of an admission and prior to the transition out of the hospital.
- At every point during care transitions, patients, family and any caregivers must know who is responsible for care and how to contact them. Care providers must also know who is responsible at each transition.
- The transition communication responsibilities of the hospital physician should be explicitly stated in policy or in medical staff bylaws.
- Concise transfer forms with key elements as identified in the MHA Safe Transitions of Care program must be sent with the patient transferring to post-acute sites of care, such as acute rehabilitation, skilled nursing facilities or transitional care facilities (http://www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/readmissions-safe-transitions-of-care).
- When a patient transfers from one facility to another, direct verbal reports between nursing staff should take place.
- Complete transition summaries should be received by the accepting facility within five business days or within adequate time to be available for the initial follow-up appointment.

Recommendations for Patients with Mental Illnesses:

- Ascertain if the patient has a county case manager, a clinic care manager or a health plan case manager and if so, notify them of the hospitalization and involve the care manager in development of the care plan and any changes to the care plan.

Other Strategies:

- Develop a universal patient care plan template that would be used by all outpatient providers and patients who may have difficulty with the widely varying formats and information.
- Utilize a patient health record that is maintained by the patient and is brought to and reviewed at all patient/provider encounters. (http://www.caretransitions.org)
- Provide access to hospital electronic health records for those facilities commonly in receipt of patients transitioned from that hospital.
- Develop as a shared resource a brief video for teaching purposes that orients the patient/family/caretaker to the need for transitions and preparation for outpatient continuing care (including both mental health and primary care providers).

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Suggested Measures

#1 Patient/Family Engagement and Activation

Percent of patients where family has been identified and releases have been obtained.

Percent of patients and/or family for whom the Teach Back method was used by care team members giving instructions on what to do during and after care transitions.

Percent of care providers who utilize health literacy standards (e.g. AHRQ Health Literacy Universal Precautions Toolkit).

#2 Medication Management

Percent of patients for whom medication reconciliation was completed on admission and discharge.

Transition plan indicates the list of active medication the patient should be taking post-transition. Medication list includes:

- Name of the medication
- Purpose of the medication
- Side effects
- How to take the medication
- When to take the medication
- Future anticipated dosage changes, i.e. titrating doses
- Current changes in the medication regime
- Possible interactions with other medications and substances such as alcohol and food

Percent of patients who successfully completed Teach Back instructions on how to take their medications and how frequently to take them.

Percent of patients whose medication plan was communicated to the next care provider(s).

Percent of patients discharged on multiple antipsychotic medications. (NQF Measure #0552)

Percent of patients discharged on multiple antipsychotic medications with justifications (three failed trials of monotherapy, plan to taper to monotherapy, augmentation of clozapine). (NQF Measure #0560)

#3 Comprehensive Transition Planning

Percent of patients who have a care plan and/or transition plan which includes the following:

- Reason for hospitalization that includes information on disease/condition in patient-friendly language (no medical jargon, acronyms or abbreviations).
- List of medications to be taken after transition (purpose, dosage, start date, frequency, how to take medication, how to obtain medication and refills).
- List of specific self-care activities (coping skills, diet, physical activity, recovery goal/plan, crisis management).
- Symptom recognition and management (symptom red flags, urgency of red flags, who to contact and what to do in an emergency).
- Follow-up appointment information (follow-up appointment scheduled within seven days of transition). (NQF Measure #0557)

Percent of patients whose care plan/transition plan was communicated to the next care provider(s). (NQF Measure #0058)

Percent of patients who have a follow-up appointment with a primary care provider within 60 days to address physical health considerations.

#4 Care Transition Support

Percent of patients who had a follow-up appointment with a provider of mental health services within seven business days post-transition.

Percent of patients who had a follow-up contact within 72 hours of transition by a care team member involved in the patient's transition.

Percent of patient who successfully completed Teach Back of instructions on how to self-manage their condition and what to do in case of warning signs.

#5 Transition Communication

Percent of patients for whom the mental health provider was notified on the same day of their admission or transition (the following morning if overnight admission).

Percent of patients for whom primary care provider was notified of their admission.

Percent of patients with a case/care manager that is notified about the hospitalization.

Percent of patients whose care plan/transition plan was communicated to the next care provider(s).

Percent of patients transferred to another facility whose information was directly communicated between care provider staff.

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Attachment D: Readmission Workgroup Themes

Summary of Themes

Low-Hanging Fruit	Unseen Causes	Additional Data Elements to Consider
1. Data and Information Sharing *2. Treatment/Care Team/ Discharge Planning* *3. Focus on the Population* *4. Duplicate Past Programs/Expand Existing*	*1. Medication/Treatment Plan/ Discharge Plan* *2. Family/Friends/Peer Support* *3. Housing/Homelessness*	*1. Different Population Comparison* *(Clients, Past Programs, Existing Programs)* *2. Expand Analysis for '14 High Utilizers'* *3. Hospital and Cost Analysis*

Participants 'Stickies' Grouped Into Themes

Low-Hanging Fruit

1. Data and Information Sharing

- Ensure appropriate representation on readmission workgroup team. Access our cohorts at various hospitals and engage them to participate in workgroup
- Sharing clinical information among Emergency Department/Hospitals/Clinicians via Beacon/HIE (Including diagnosis, medications, case management, housing, public assistance, etc.)
- Hospital use of Anasazi
- Optum to inform admitting hospital of any other recent admissions
- Assign a primary psych provider to a client to avoid duplication of services

2. Treatment/Care Team/ Discharge Planning

- Ensure follow-up at discharge
- Treatment Options
- Case Management starts upon admission, and follows patient through discharge (housing, medication, provider, communication, and coordination)
- Appropriate discharge placement (Housing 1st model)
- Pay more attention to medication side effects
- More intensive discharge planning after a jail assignment
- Evaluate Length of Stay and stabilization to see if a client should be in the hospital longer to decrease risk of readmission

3. Focus on the Population

- Root Cause Analysis of '14 High Utilizer Clients'
- Narrow the focus of group after we have decided which population to focus on
- Medical Record biopsy on the '14 High Utilizer Clients'

4. Duplicate Past Programs/Expand Existing

- SHARI – Revisit program and outcomes
- Expand existing programs (BTR and HOPE)
- Intensive case management for Medi-Cal population like LIHP

Unseen Causes

1. Medication/Treatment Plan/ Discharge Plan

- Poor quality of treatment
- Medication noncompliance
- Co-morbid substance abuse
- Inconsistent medication use
- Clients are unable to get medications filled
- Clients may not want to or be ready to leave the hospital
- Over prescribed benzodiazepines and opioids
- Communication
- Lack of a warm hand off from inpatient to continuing care programs
- Lack of Healthcare integration (Fragmentation)
- Non-compliance in treatment plan
- Outpatient programs need psychiatrist onsite who can address crisis situations or risk factors

2. Family/Friends/Peer Support

- Lack of contact with family and friends
- Peer Support

3. Housing/Homelessness

- Homelessness
- Low resources for housing

Additional Data Elements to Consider

1. Different Population Comparison
(Clients, Past Programs, Existing Programs)

- Expand sample size
- Medi-Medi Data
- SHARI outcome data
- Bridge to Recovery Pre/Post
- Indigent Population
- Outpatient programs no t included in Anasazi (Bridge to Recovery)

2. Expand Analysis for '14 High Utilizers'

- Trend in when readmissions occur (Holidays, weather, etc.)
- Correlation between homelessness and readmissions
- Aggregate data because of low sample size
- Root Cause Analysis of 14
- Housing Status
- Discharge Reason

3. Hospital and Cost Analysis

- 5 year trend of cost of readmissions
- Readmissions by Hospitals

Best Practices -- Commonalities through Multiple Programs That Help Clients with Connection to Services

Support from Peers with Lived Experience: Programs found that peer/family specialists could often connect with clients more effectively, because peer/family specialists can relate to clients and provide a positive role model as an individual in recovery. Some programs have noted that their coaches have been trained to listen to their clients and work collaboratively with them.

Supporting Clients in Gap Period While Connecting with Services: Crises and relapses can often occur due to difficulty with navigating systems of care, such as setting up follow-up appointments or being put on waiting lists for treatment. Bridge to Recovery noted that "we do not merely give clients a list of numbers to call. We make the calls with the clients to make sure they get the appointments. And then we teach them how to make the calls for themselves for the future." Hope Connections noted that their support staff will wait with a client while they are in the waiting room or triage before receiving clinical services, so that the clients feel more secure and comfortable while waiting.

Programs have helped clients with their needs during the critical transition period of time right after discharge from inpatient services, and also while on waiting lists to receive services. Several programs have emphasized the importance of having the client receive services – outpatient services, a meeting with a transition coach, or both – in the week immediately following discharge.

Types of Support Given to Clients -- Connection with Services: Programs help clients with scheduling follow-up appointments. This can include making the calls with the client, and explaining to providers of services it is important for the client to receive services within a week after discharge. Programs help clients with connecting to services for basic needs such as food, shelter, employment, education, medication, and socialization (such as clubhouses).

Types of Support Given to Clients -- Coaching and Social Support: Programs help clients by teaching wellness self-management skills. This can include recognizing when one's symptoms are worsening and knowing that it is important to seek behavioral health services before a crisis begins or escalates. It can also include knowing how and when to take one's medication. Many programs have identified empowering clients as an important value. This can include helping the client to develop a Wellness Recovery Action Plan (WRAP) or similar goals and strategies for accomplishing these goals.

It is important to make sure that skills taught to clients are understood. The RARE (Reducing Avoidable Readmissions Effectively) Campaign suggested using the Teach-Back method in order to ensure that information or skills are understood. In this method, the client is asked to teach the skill back to the practitioner or coach.

Engaging Support Systems: If the client consents, a program can interact with their family or other designated loved ones in order to coach them on how to support their loved one during the period of transitioning from inpatient care to outpatient. This can include helping the client with medication compliance. Clubhouses and peer support coaches can also be a helpful part of the client's social support system.

Connecting With Homeless Clients: It can be a challenge to remain in contact with a client who does not have a consistent address or telephone number. Programs work proactively to keep in touch with these clients so that they do not slip through the cracks. This can include going to the area where the client usually sleeps or spends time, and some programs have also found that giving clients cell phones helped with maintaining contact. Also, programs have helped clients to apply for housing services and connect with shelters and crisis residential facilities.

Some programs have found that homeless clients are more likely to readmit to inpatient psychiatric hospitalization during times of stress, including nights with bad weather or when they cannot meet needs for essentials such as food. Readmissions can be reduced by connecting clients to the appropriate services for these needs.

Connecting With Appropriate (and Less Expensive) Services: Programs aim to connect clients with outpatient services so that they can have a stable life outside of inpatient care.

It is common for clients who are enrolled in these programs to decrease their utilization of services that are more expensive and focused on crisis-stabilization services, such as inpatient hospitalizations. It is also common for enrolled clients to increase their utilization of services that are more cost-effective and focused on recovery, such as outpatient services and connections to social support such as clubhouses.

Attachment F: FFS Inpatient Psychiatric Summary Readmission Rates

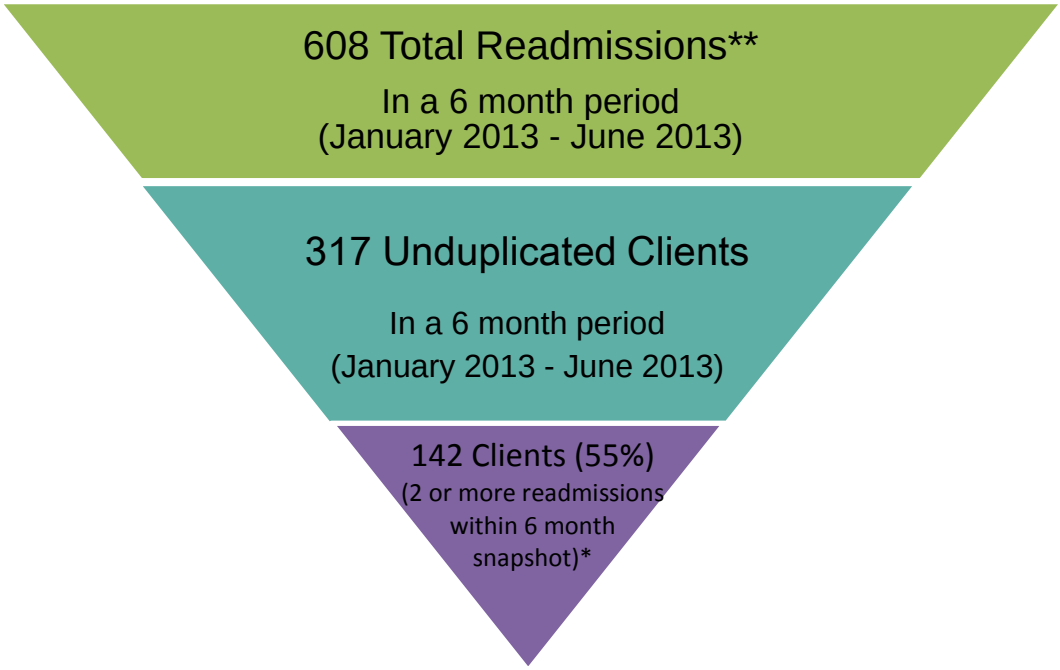
Fiscal Year	FY 10/11				FY 11/12				FY 12/13			
Hospital	Readmission Rate	Readmissions	Admissions	Unique Client	Readmission Rate	Readmissions	Admissions	Unique Client	Readmission Rate	Readmissions	Admissions	Unique Client
OUT OF COUNTY FFS HOSP ADULT	28.09%	25	89	68	22.54%	16	71	59	42.45%	45	106	63
Hospital A	23.16%	261	1,127	794	24.49%	217	886	683	21.01%	87	414	351
Hospital B	29.63%	8	27	23	24.00%	6	25	23	28.38%	21	74	57
Hospital C	22.54%	48	213	166	21.50%	46	214	163	16.98%	36	212	167
Hospital D	8.70%	2	23	22	23.08%	3	13	11	20.83%	5	24	19
Hospital E	25.74%	96	373	285	27.45%	115	419	312	24.62%	113	459	349
Hospital F	18.72%	38	203	182	30.43%	84	276	225	21.29%	56	263	225
Hospital G	8.70%	2	23	20	4.00%	1	25	24	20.29%	14	69	61
Hospital H	26.23%	139	530	391	29.41%	160	544	410	29.07%	182	626	453
Hospital I	17.83%	56	314	254	19.49%	69	354	297	20.32%	103	507	395
Hospital J	27.94%	195	698	473	29.40%	254	864	585	32.13%	365	1,136	694
Hospital K	19.25%	46	239	190	19.92%	53	266	205	20.96%	61	291	213

Note: Readmission rate definition: Readmission rate is defined as the percentage of patients who had at least one readmission within a 30 day period. These are clients were rehospitalized to the same or another psychiatric hospital within 30 days of their last discharge.

Hospital readmission rate example:

- 1st readmission at A with previous discharge at A – Credited to A
- 2nd readmission at B with previous discharge at C - Credited to C
- 3rd readmission at D with previous discharge at B – Credited to B
- 4th readmission at B with previous discharge at D – Credited to D
- 5th readmission at B with previous discharge at B – Credited to B

Medi-Cal Readmission Client Data Report
6 Month Snapshot: January 2013 – June 2013



* 142 Clients, (55%) have more than one readmission within the 6 month period. Fifty-five percent of the time the clients that appear on the CO-4 Report, presented at the Hospital Partners Meeting are the same clients month over month.

# of Readmissions	Clients
1	175
2	79
3	30
4	12
5	9
6	7
9	3
10	1
13	1
Total	**317**

Range Number of Times a Client Readmitted	1 – 13
Average Number of Readmissions Per Client	1.92

**Medi-Cal Authorizations only, does not contain indigent clients

APS Healthcare

California EQRO

Feb 2013 – Updates to document noted in blue.

- This outline is a compilation of the "Road Map to a PIP" and the PIP Validation Tool that CAEQRO uses in evaluating PIPs. The use of this format for PIP submission will assure that the MHP addresses all of the required elements of a PIP. The MHP is not limited to using this format and may submit evidence of the PIP in other formats which address the required elements.
    - PDSA Cycles can be submitted as separate documents or outlined as part of #3 barrier analysis (understanding causes), #10 interventions (testing change ideas), as well as #15 data analysis and triggering changes. Conducting PDSA cycles is for purposes of learning and testing; many PDSA cycles in themselves do not complete a PIP.
- Your PIP should focus on a consumer-related problem (access, timeliness, outcomes) which is measured (indicators), for which interventions will be applied to create improvement. Simply setting up a monitoring system for some facet of care is not a PIP unless it is focused on improving an indicator.
- Do not set up a PIP to evaluate the effectiveness of a given program; this is a program evaluation. The individuals receiving the intervention need to be related to the identified problem, upon which various interventions (not just a program's services) can be tested and applied to create improvement.
- You are not limited to the space in this document. It will expand, so feel free to use more room than appears to be provided, and include relevant attachments.
- Emphasize the work completed over the past year, if this is a multi-year PIP. A PIP that has not been active and was developed in a prior year may not receive "credit."
- PIPs generally should not last longer than roughly two years. An MHP is advised to consult with CAEQRO before continuing a PIP into a third year.

CAEQRO PIP Outline via Road Map

MHP: County of San Diego, Behavioral Health Services
Date PIP Began: February 7, 2013

Title of PIP: Trauma-Informed Care Interventions at Southeast Mental Health Clinic
Clinical or Non-Clinical: Non-Clinical

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

There are three primary stakeholder groups involved in the development and implementation of this PIP.

1. Core Implementation Team members:
    - Greg Watson LCSW – County of San Diego, Southeast Mental Health Center, Adult/Older Adult Program Manager
    - Anne Fitzgerald LCSW - County of San Diego, Southeast Mental Health Center, Children, Youth & Family Program Manager
    - Berenice Badillo LMFT - County of San Diego, Southeast Mental Health Center, Adult/Older Adult Licensed Mental Health Clinician
    - Aldo Vereo - County of San Diego, Southeast Mental Health Center, Office Assistant
    - Erin Springer -San Diego State University, MSW/MPH Intern with the County of San Diego, Behavioral Health Services
    - Louise Zavala LMFT - County of San Diego, Southeast Mental Health, Children, Youth & Family Licensed Mental Health Clinician
    - Terry Maxson, LCSW – Harmonium, Transitional-Age Youth Program Manager
    - Juan Estrada - Harmonium
    - Holly Jones - Family & Youth Round Table
    - Mario Martinez – Consumer Representative
    - Patricia Fulgencio – Family Member Representative
2. Steering Committee:
    - Alfredo Aguirre LCSW - County of San Diego, Behavioral Health Services, Director
    - Susan Bower MSW, MPH - County of San Diego, Behavioral Health Services, Director of Operations
    - Katie Astor LCSW - County of San Diego, Behavioral Health Services, Assistant Deputy Director, Children, Youth, & Family
    - Piedad Garcia Ed.D, LCSW - County of San Diego, Behavioral Health Services, Assistant Deputy Director, Adult/Older Adult
    - Tabatha Lang - County of San Diego, Behavioral Health Services, Quality Improvement
    - Greg Watson LCSW - County of San Diego, Behavioral Health Services, A/OA Program Manager, Southeast Mental Health Clinic
    - Anne Fitzgerald LCSW- County of San Diego, Behavioral Health Services, CYF Program Manager, Southeast Mental Health Clinic
    - Wendy Maramba LMFT - County of San Diego, Behavioral Health Services, Chief, Children, Youth, & Family
    - Sabrena Marshall MPH - County of San Diego, Behavioral Health Services, Prevention Planning Unit
    - Liz Miles, MPH, MSW – County of San Diego, Behavioral Health Services, Quality Improvement

- Donna Ewing-Marto - Family & Youth Round Table, Director
- Judi Holder - Recovery Innovations, Director

3. Technical Support from the National Council of Behavioral Health:
   - Linda Ligenza MSW – Clinical Services Director
   - Cheryl Sharp MSW, ALWF – Senior Advisor for Trauma-Informed Services
   - Jordan Winn – Consulting Associate

"Is there really a problem?"

2. Define the problem. Describe the data reviewed and relevant benchmarks that validate the problem exists. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

According to SAMHSA's current definition developed in 2012, "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."

The National Council for Behavioral Health report from 2012 indicates more than 59% of the general population has experienced at least one adverse childhood event (ACE). The ACEs Study is perhaps the most important epidemiological study done to track health risks. The study asked participants 10 questions about adverse childhood experiences/events. Included were questions regarding childhood sexual abuses and neglect, experiencing or witnessing violence or living in a home with a parent who had mental illness, substance use disorders or having a parent who was incarcerated. The answers were correlated with mental and physical health issues. An ACE score of 4 or more increases your risk of heart disease even if you are not a smoker or overweight. Having a high ACE Score increases your risk of cancer, pulmonary disease, diabetes and a host of other illnesses.

This is a priority problem for the County of San Diego as among those receiving adult/older adult services in San Diego County in FY 2011-2012, 18,038 (37.4%) reported they had experienced trauma and 14,287 (29.4%) reported having been abused as a child. Given the local prevalence and impact of trauma, the County of San Diego behavioral health system contracted with a consultant in January 2012 to determine the current level of trauma-informed competency. This assessment also included providers contracted with the County. Throughout the assessment, four questions guided the work: 1. What are the general interpretations of trauma-informed systems/agencies? 2. What are the different individual interpretations – is there a pattern? 3. What are the central themes (and subthemes) regarding the impact of trauma on practice and policy? 4. What are the impressions of vicarious trauma and the need for self-care among staff and providers?

There were three main components of the assessment: Key Informant Interviews; Survey to all Behavioral Health Staff and Providers; and Site-visits/observations of the agency and providers working with and associated to Behavioral Health. Grounded Theory methodology guided the data collection and analysis (Glaser, 1978 & 1992). This theory consists of five basic components: Theoretical sensitivity, theoretical sampling, coding, theoretical memoing, and sorting. These components were saturated in a constant comparative method of analysis. The goal of this work was to understand the level of trauma-informed competency and to assess current levels of understanding regarding trauma-informed care, the difference between trauma-sensitivity compared to trauma-specific interactions and the existing interventions in Behavioral Health.

First, working with the County of San Diego, the consultant identified candidates for key informant interviews. There were 19 interviews conducted. During the interview, the Key informants were also asked who else should be contacted to ensure the target areas outlined in the contract were represented. The Consultant created a Key Informant Interview matrix to show the range of views representing diverse backgrounds and covering key areas of the Behavioral Health systems and identified collaborations. Several items were pulled from the interview transcripts: "long held practices by old school staff and providers" and integration issues surrounding current initiatives that "aren't getting relayed to those on the front line due to a gap between the higher ups and those of us in the front lines." One informant stated, "If you wanted to be the super best trauma informed counselor, advisor, psychiatrist, therapist what three things would you need to really be able to do that with most your clients? I don't think they could say."

Second, a survey was created from patterns that emerged from the interviews and aligned with evidence-based practices currently surrounding trauma-informed systems. The survey was reviewed and approved by the contract manager and was disseminated countywide with a total of 796 individuals completing (88%). The results indicated only 44% knew what Trauma Informed Care is and only 34% knew how to apply Trauma Informed Care. Seventy-two percent of respondents acknowledge a lack of universal screening for trauma. Only 50% knew how to ask about trauma and would know how to respond. These findings confirm what was found in the interviews: variable agreement on trauma-informed systems and the need for cross-system trainings.

Finally, site-visits/observations were conducted at 20 sites including Child and Adult Mental Health Programs, Alcohol and Drug Services sites (male and female programs), Family Support Partner organizations for both children and adults, a LGBT dual diagnosis program, a homeless shelter, Rady Children's Hospital Chadwick Center, Neighborhoods for Children, public health departments, CWS, and the CADRE initiative. The data was triangulated and culminated into nine recommendations: (a) Shared Philosophy & Leadership Commitment; (b) Universal Screening; (c) Step-wise, cross-system training; Interconnect Recommendations to Existing County Initiatives; (d) Prioritize Self-care and Wellness for Staff and Providers; (e) Shared Resources, Materials and Database; (f) Integrated Trauma Informed Systems to include (Practices, Policies, Place, Contract Language, Supplemental Materials, and Utilization of Electronic Records and Databases); (g) Meaningful and Consistent Evaluation and Consultation; and (h) Consumer/Clients are Partners in Care. In addition, several local, state and national documents were reviewed in efforts to validate the findings and support the recommendations.

In an effort to address the needs of the population and to raise awareness and improve clinical outcomes for trauma survivors, the County of San Diego, HHSA Behavioral Health Services (BHS) applied, and was accepted, into the National Council of Behavioral Health's nationwide Trauma Informed Care Learning Community which kicked off at the National Council's annual conference April 7-11, 2013 in Las Vegas. By joining with other organizations across the nation, BHS reviewed best practices and lessons learned to create and sustain a trauma-informed system of care tailored to meet the needs of San Diego County. The National Council provided technical assistance, tools and educational support to facilitate the change process and support not only the efforts of BHS, but all agencies and organizations that want to be involved. Our efforts were first focused at Southeast Mental Health Clinic, which serves both Adult/Older Adult and Children, Youth and Families with the goal to then extend the initiative throughout our system of care once the desired level of success is achieved.

By engaging in the National Council's Trauma-informed Approaches Learning Community BHS is working to change organizational culture by:

- Training all staff on how each person can make a difference by their behaviors and how we treat each other; promoting staff self-care and a recognition that staff also have been exposed to traumatic life experiences; and creating an environment where everyone feels safe.
- Working to provide trauma-specific and trauma-focused evidence-based best practices using psycho-educational groups, trauma focused therapies as well as using established practices that support this work, such as Motivational Interviewing or WRAP classes for healing trauma.
- Collaborating with our community partners to make certain they also understand the importance of the impact of trauma and are providing trauma-informed approaches in order that those we serve are not re-traumatized within the community.
- Developing quality assurance that the work being completed is making a difference, striving for a transparent system that allows for feedback from consumers, staff and the community in order to increase buy-in and to improve services.

By joining the National Council Learning Collaborative, BHS believes the adoption of trauma-informed approaches will makes us a better organization and that this is a team approach that not just changes lives, but changes cultures and communities. This project will directly impact the clients served at Southeast Mental Health Clinic, but the lessons learned are intended to spread throughout BHS at all levels.

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. a) What are the likely causes of the problem? Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

Trauma is prevalent throughout BHS as evidenced by 18,038 (37.4%) of individuals served report they had experienced trauma and 14,287 (29.4%) report having been abused as a child in FY 2011-12. The National Council estimates that over 90% of those receiving services within the mental health system have experienced significant adverse childhood events.

Initial data that was gathered and analyzed to understand the barriers of implementing a trauma-informed system in San Diego County's BHS included data on the prevalence of reported trauma and the data collected as part of the 2012 Trauma-Informed Care BHS Assessment. Based on a survey distributed to staff, the results indicated a need to focus on the education and support of behavioral health staff to ensure successful integration of trauma-informed care principles.

The survey was created from patterns that emerged from the key informant interviews and aligned with evidence-based practices currently surrounding trauma-informed systems. The survey was disseminated countywide with a total of 796 behavioral health staff completing. This survey was conducted to determine a baseline of the workforce's knowledge and preference for future trainings. The survey produced the following results:

Survey Topic	Percent Responding Yes to Question
Do you know what Trauma Informed Care is?	44%
Do you know how to integrate Trauma-Informed Care Principles?	34%
Do you acknowledge a lack of universal screening for trauma?	72%
Do you know how to ask about trauma and would know how to respond?	50%
Do you believe it is possible to hold people accountable and be Trauma Informed?	77%

b) What are barriers/causes identified that require intervention? Use Table A, and attach any charts, graphs, or tables to display the data.

Staff indicated knowledge of trauma informed care, integration of its principles and how to effectively ask questions regarding trauma as barriers, BHS targeted workforce education. Trauma informed care principles also emphasize the importance of creating a safe and secure environment to prevent retraumatization. The purpose is to give consumers a voice to safely let staff know when practices and policies are inconsistent with trauma informed principles. Therefore creating a safe and secure environment was also addressed.

Table A – List of Validated Causes/Barriers

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
Trauma-informed, educated and responsive workforce	Staff survey was distributed to the staff at Southeast Mental Health Clinic at the beginning of the pilot project- See Attachment A for survey results; client satisfaction survey
Create Safe and secure environment	A Consumer survey was issued at Southeast Mental Health Clinic to the individuals coming in for services during the early period of the pilot project- See Attachment B for survey results; client satisfaction survey

Formulate the study question

4. State the study question. This should be a single question in 1-2 sentences which specifically identifies the problem for improvement, the general intervention, and the desired outcome.

Will targeted interventions at the Southeast Mental Health Clinic including trauma informed care training, staff development, change in practices and creating a warm and welcoming environment result in increased staff trauma informed care competencies and consumer satisfaction?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain. (Remember that all PIPs must include Medi-Cal beneficiaries)

Yes, as this is a non-clinical PIP the focus is on developing the workforce and creating a safe and welcoming environment for the beneficiaries served at the Southeast Mental Health Clinic.

6. Describe the population to be included in the PIP, including the number of beneficiaries.

The population targeted in this non-clinical PIP is the staff in both the Children, Youth and Family program and the Adult/Older Adult program at Southeast Mental Health Clinic. The beneficiaries that will be impacted through this pilot project include an estimated 472 TAY, adults, and older adults and 176 children and youth, based on the number of clients that received specialty mental health services in FY 2011-12.

7. Describe how the population is being identified for the collection of data.

BHS identified Southeast Behavioral Health Clinic for the pilot project due to its location in an underserved community, serving both children and adult populations, and its co-location with a primary care clinic. Data was collected to represent both the Adult/Older Adult and Children, Youth and Family programs. Data will include an employee survey pre and post on trauma-informed care; a pre and post client survey on the environment at Southeast Mental Health Clinic; and pre and post data for client satisfaction for the Southeast Mental Health Clinic.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

A sampling technique was not used.

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

Employee Survey:

14 staff members responded to the Trauma Informed Care staff survey in August 2013. This constitutes a majority of the staff of Southeast Mental Health Clinic. Staff include clinicians, psychiatrists, office assistants, program managers, and a medical records clerk.

"Safe and Secure Environment" Consumer Survey:

57 surveys (54 of them complete) were submitted between October 14-25, 2013. Given the estimate of roughly 648 consumers based on data from FY 2011-2012 (as detailed in the answers to questions #6), this constitutes about 8.8% of the total number of beneficiaries. However, given that surveys were collected over a period of only 2 weeks, this constitutes a very good survey response rate. It is more likely for survey results to be deemed statistically significant when the number of respondents is greater than 30 (Source: Lowry 2013, "Concepts and Applications of Inferential Statistics," available online at: http://vassarstats.net/textbook/index.html), so by this measure as well we deem this to be a large enough sample size to render a fair interpretation.

Consumer Satisfaction Survey:

Unfortunately, the number of consumers who complete the annual satisfaction survey continues to constitute a relatively small fraction of the total number of consumers. This makes it unlikely for changes in scores on this survey to be deemed statistically

significant, even if the quality of the care provided to consumers has been significantly enhanced in actuality. Number of responses included:
CYF Pre-Intervention (August 2012) – completed by parent: 12
CYF Mid-Intervention (August 2013) -- completed by parent: 4
CYF Pre-Intervention (August 2012) – completed by youth: 5
CYF Mid-Intervention (August 2013) -- completed by youth: 4
A/OA Pre-Intervention (August 2012) -- 24 respondents
A/OA Mid-Intervention (August 2013) -- 18 respondents

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

9. What indicators were selected to measure improvement?

The Satisfaction Domain and Participation in Treatment Planning Domains of the annual Consumer Satisfaction Survey (both the survey for adult consumers and the surveys completed by both parents and by youth for youth consumers) were selected. These surveys are taken in August of each year.

The Trauma-Informed Care staff survey was given to the staff of Southeast Mental Health Clinic in August 2013. A follow-up survey will be taken in April 2014 after the intervention is complete.

A "Safe and Secure Environment" Consumer Survey was given to consumers in October 2013. A follow-up survey will be taken in April 2014 after the intervention is complete.

a) Why were these performance indicators selected?

The Satisfaction Domain and Participation in Treatment Planning Domains of the annual Consumer Satisfaction Survey were selected because the goals of the intervention are to increase consumer satisfaction and to increase staff trauma informed care competencies. The Satisfaction Domain is a direct match for the goal of increasing consumer satisfaction. An important competency in the principles of trauma-informed care is the participation of the client is treatment planning, which the Participation in Treatment Planning Domain serves to measure.

The Trauma-Informed Care staff survey was selected because its questions are a measure of staff competency in trauma informed care and a system-wide baseline was already established.

A "Safe and Secure Environment" Consumer Survey was selected because it asks consumers specifically about how comfortable and welcomed they feel in the environment of the clinic. This is relevant because the principles of trauma-informed care emphasize making the consumer feel comfortable and welcomed.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?
Include process indicators that reflect monitoring the application of the interventions.

As the three performance indicators will be based on pre and post survey results, the on-going monitoring of these domains have occurred through the twice monthly meetings of the Core Implementation Team at Southeast Mental Health Clinic. These domains are discussed, in addition to strategies to address the domain, success stories, and/or lessons learned (See Attachment C- Meeting Minutes). The pre and post measurement will assess change over time to see if there has been a notable difference in the staff's awareness of trauma-informed principles, if clients recognize the changes implemented in the environment, and if there is a positive change in the overall satisfaction from the clients receiving mental health services at the Southeast Mental Health Clinic.

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

Table B – List of Performance Indicators, Baselines, and Goals

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
1	Staff Trauma-Informed Self Assessment	Percent who check box indicating staff training has included: "What is Trauma Informed Care," "How to apply and integrate Trauma Informed Care," and "How to ask about trauma and know how to respond if disclosure is made."	No denominator	85.7% said training has included "What is Trauma Informed Care," 35.7% said training has included, "How to apply and integrate Trauma Informed Care," and 28.6% said training has included, "How to ask about trauma and know how to respond if disclosure is made."	No specific numeric goals were set. It should be mentioned that it may not be appropriate to expect 100% of staff to say they have been trained on each item. For example, it may not be appropriate for a security guard or receptionist to ask about trauma.
2	Safe and Secure Environment Consumer	# that agree or strongly agree to the three	Total # who responded to	89% agree or strongly agree to: "I feel	No specific numeric

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
	Survey	statements in this survey	survey	welcomed at Southeast Mental Health Center." 83% agree or strongly agree to: "The waiting room makes me feel comfortable." 91% agree or strongly agree to: "The facility makes me feel comfortable."	goals were set
3	Adult Consumer Survey Scores – Southeast Clinic: Satisfaction Domain (overall)	Average Score	No denominator, although 5 is the maximum possible score.	Average Score: 4.3	No specific numeric goals were set
4	Adult Consumer Survey Scores – Southeast Clinic: Participation in Treatment Planning Domain (overall)	Average Score	No denominator, although 5 is the maximum possible score.	Average Score: 4.2	No specific numeric goals were set
5	Youth Service Survey scores: Southeast Clinic: Family Form (Completed by Parent/Caregiver): Satisfaction	Percent who agree / strongly agree with the statement: "Overall, I am satisfied with the services my child received."	No denominator, although 100% is the maximum possible score	81.8% agree / strongly agree with the statement: "Overall, I am satisfied with the services my child received."	No specific numeric goals were set
6	Youth Service Survey scores: Southeast Clinic: Youth Form (Completed by Youth): Satisfaction	Percent who agree / strongly agree with the statement: "Overall, I am satisfied with the services my child received."	No denominator, although 100% is the maximum possible score	100% agree / strongly agree with the statement: "Overall, I am satisfied with the services my child received."	No specific numeric goals were set
7	Youth Service Survey scores: Southeast Clinic: Family Form (Completed by Parent/Caregiver): Participation in Treatment Planning	(Percentage of clients who agree with the statement "I helped to choose my child's services" + Percentage of clients who agree with the statement "I helped to choose my child's treatment goals" + Percentage of clients who agree with the statement "I	Divided by 3 (for 3 questions)	90.33%	No specific numeric goals were set

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator (number)	Goal (number)
		participated in my child's treatment")			
8	Youth Service Survey scores: Southeast Clinic: Youth Form (Completed by Youth): Participation in Treatment Planning	(Percentage of clients who agree with the statement "I helped to choose my services" + Percentage of clients who agree with the statement "I helped to choose my treatment goals" + Percentage of clients who agree with the statement "I participated in my treatment")	Divided by 3 (for 3 questions)	86.66%	No specific numeric goals were set

10. <u>Use Table C to summarize interventions</u>.

a) In column 2, describe each intervention.
b) In column 3, identify the barriers/causes each intervention is designed to address.
c) In column 4, identify the corresponding indicator which will measure the performance of each intervention.
d) Do not cluster different interventions together.

Table C - Interventions

1) Number of Intervention	2) List each specific intervention	3) Barrier(s)/causes each specific intervention is designed to target	4) Corresponding Indicator	5) Dates Applied
1	Southeast Mental Health Clinic staff and community partners meet biweekly to discuss Trauma-Informed Care principles and to give feedback regarding their interactions with clients in which they have attempted to utilize these principles.	1) Increasing client satisfaction 2) Increasing staff competency in trauma-informed care principles 3) Increasing client's feelings of safety and comfort	1) Satisfaction Domain of Client Surveys 2) Trauma-Informed Care staff survey 3) "Safe & Secure Environment" Consumer Survey	April 2013-current
2	Southeast Mental Health Clinic has implemented changes in the environment. These include: light fixtures and carpet replaced; soda	1) Increasing client's feelings of safety and comfort	1)"Safe & Secure Environment" Consumer Survey 2) Satisfaction	April 2013-current

1) Number of Intervention	2) List each specific intervention	3) Barrier(s)/causes each specific intervention is designed to target	4) Corresponding Indicator	5) Dates Applied
	machine and noisy toys removed from the reception area; plants were added; client artwork hung in hallway; added a positive comment tree in the reception area; changed the TV display to calming shows.		Domain of Client Surveys	
3	Southeast Mental Health Clinic has implemented staff training. These include: an introduction luncheon sponsored by leadership to discuss TIC with staff, introduction video "Trauma Lens" to security staff; in person training for support staff and security on the principles of TIC and how to interact with clients to create a welcoming environment; all clinicians attend Seeking Safety training scheduled in March, 2014.	1) Increasing staff competency in trauma-informed care principles	1) Satisfaction Domain of Client Surveys 2) Trauma-Informed Care staff survey,	April 2013-current

See Attachment D for the timeline for the interventions

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

Consumer surveys are collected each August for programs within the County of San Diego System of Care, for both services provided to Adult/Older Adult (A/OA) and to Youth. Survey results from August 2012 (pre-intervention) and August 2013 (mid-intervention) were compared to determine if the interventions affected client satisfaction and participation in treatment planning.

The data from the surveys given to A/OA is published in a yearly report by the Health Services Research Center (HSRC).

For the survey given to A/OA, the Satisfaction Domain had three statements:

1) I liked the services that I received at this program.
2) If I had other choices, I would still choose to get services from this program.
3) I would recommend this program to a friend or family member.

For the survey given to A/OA, the Participation in Treatment Planning Domain had two statements:

1) I felt comfortable asking questions about my treatment and medication.
2) I, not staff, decided my treatment goals.

In the report published by HSRC, an overall score is generated for each question and each domain by assigning score values to each answer (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree, 0 = Not Applicable) and calculating the average score for each question and for each domain. Additionally, the percentage of respondents who agree or strongly agree to each statement was reported.

For the data from the surveys related to Youth Services, a report called Youth Services Survey (YSS) Results is published by Children and Adolescent Services Research Center (CASRC). A survey is given to youth who are clients, and a similar survey is given to the parent / caregiver of the youth who are clients.

In these surveys, one statement was identified as pertaining to the domain of Satisfaction:

1) Overall, I am satisfied with the services I received (Youth Survey) / Overall, I am satisfied with the services my child received (Parent / Caregiver Survey)

Three statements were identified as pertaining to the domain of Participation in Treatment Planning Domain:

1) I helped to choose my services (Youth Survey) / I helped to choose my child's services (Parent / Caregiver Survey)
2) I helped to choose my treatment goals (Youth Survey) / I helped to choose my child's treatment goals (Parent / Caregiver Survey)
3) I participated in my own treatment (Youth Survey) / I participated in my child's treatment (Parent / Caregiver Survey)

In the Youth Services Survey (YSS) Results report, the percentage of youth and the percentage of parents / caregivers who strongly disagree / disagree and the percentage who agree / strongly agree are reported.

In addition to the annual consumer surveys, two special surveys were conducted to gather information related to this intervention. These are the "Safe & Secure Environment" Consumer Survey and the Trauma-Informed Care staff survey.

The "Safe & Secure Environment" Consumer Survey had 54 complete responses submitted between October 14th – 25th. A follow-up survey will be conducted in April 2014 after the intervention has been completed. This survey has 3 statements for consumers to indicate their level of agreement or disagreement with:

- I feel welcomed at Southeast Mental Health Clinic.
- The waiting room makes me feel comfortable.
- The facility makes me feel comfortable.

The Trauma-Informed Care staff survey was completed in August 2013 by 14 staff of Southeast Mental Health Clinic, and a follow-up survey will be conducted in April 2014 after the intervention has been completed. This survey has 61 questions or statements for staff to agree or disagree with. These statements involve how much a program's policies are informed by the principles of Trauma-Informed Care, such as:

- The program and/or agency provides opportunities for staff input into program practices (e.g., when and where intakes occur) and policies (e.g., decisions about funding -- when a service has to end due to the expiration of funding)
- A universal trauma-screening tool is provided to all consumers
- Consumers are asked where they want to conduct the intake

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.

The annual consumer survey data is collected by anonymous paper survey of the consumers of services for Adults and Youth. This is existing data which is collected yearly.

The "Safe & Secure Environment" Consumer Survey is an anonymous paper survey, offered in English and Spanish, of the consumers of services for Adults and Youth. This is not existing data, but rather was a special survey taken for the purpose of gathering information related to participation in the National Council as well as to this PIP.

The Trauma-Informed Care staff survey is an anonymous online survey of the staff of Southeast Mental Health Clinic. This survey was developed by the consultant, Dr. Dawn Griffin, initially to assess the system-wide level of trauma-informed care competencies.

13. Describe the plan for data analysis. Include contingencies for untoward results.

The plan is to compare the results of the surveys of consumers of Adult/Older Adult and Youth services at Southeast Mental Health Clinic from August 2012 (before the intervention began) and August 2013 (after the intervention began). The specific domains to be considered for comparison are Satisfaction and Participation in Treatment Planning.

There are no contingencies for untoward results. The plan is to report the data to leadership and the Southeast Mental Health Clinic for continuous learning and change.

It is important to note that the intervention officially began in April 2013, and it will not end until April 2014. Therefore, the consumer survey for August 2013 took place only 4 months after the intervention began. The results of this survey will not give a full picture of the impact of the intervention. The results of the survey that will take place in August 2014 – 4 months after the intervention ends – may provide a more complete picture of the impact of the intervention on consumer perceptions of their treatment.

There are other measures for which a pre-intervention measurement was collected, for which a post-intervention measurement has not been collected but will be collected in April 2014 after the intervention ends. One such measure is a Trauma-Informed Care staff survey that was completed in August by the 14 staff of Southeast Mental Health Clinic.

A post-intervention assessment using the Trauma-Informed Care staff survey will provide important information regarding how the intervention has increased the staff's awareness of the principles of Trauma-Informed Care, and how policies have been improved in order to incorporate these principles. It is likely that this measure will provide more robust evidence of improvement than the consumer surveys, because the intervention is targeted directly to educating staff about the principles of Trauma-Informed Care.

Another measure for which post-intervention data has not yet been collected is the "Safe & Secure Environment" Consumer Survey. This survey, which had 54 complete responses submitted between October 14th – 25th, had 3 statements for consumers to indicate their level of agreement or disagreement with:

- I feel welcomed at Southeast Mental Health Clinic.
- The waiting room makes me feel comfortable.
- The facility makes me feel comfortable.

A follow-up survey will be administered April 2014 to determine whether consumers feel more comfortable and welcomed at Southeast Clinic after the intervention has been completed. There is reason to anticipate that the results of this survey may not be completely robust in demonstrating the improvements produced by this intervention. One reason is that no pre-intervention measurement was taken; the initial survey was administered in October six months after the intervention began. Therefore, it is not possible to determine a true baseline. It is possible that the level of consumers' feeling of comfort and welcome as of October 2013 was improved from the level before the intervention began. While it is possible that the follow-up survey in April 2014 will show an improvement over the second six months of the intervention, the survey responses in October 2013 were highly positive (89%, 83%, and 91% of consumers surveyed agreed or strongly agreed on the three statements, respectively), and therefore there is somewhat limited room for measureable improvement.

The reason that the Trauma-Informed Care staff survey was not conducted until August 2013 and the "Safe & Secure Environment" Consumer Survey was not conducted until October 2013 is that it takes a number of months for any survey to be officially approved for use by BHS. The surveys were developed around the time that the intervention began, but they were not approved for use until October 2013. The decision was begin the intervention in April than to delay the intervention by a period of months in order to wait until after the survey was conducted.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

The staff survey was created by Dr. Dawn Griffin, a forensic psychologist working as a consultant for the County of San Diego on this project. The staff survey was an electronic survey that was completed online, while the consumer surveys were paper surveys that were distributed to consumers by the staff of Southeast Mental Health Clinic.

The data analysis was performed by:

- Liz Miles, MPH, MSW -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Principal Administrative Analyst
- Brian Hammond, MBA, M.S. -- County of San Diego, Behavioral Health Services, Quality Improvement, Performance Improvement Team, Research Analyst
- Erin Springer, San Diego State University, MSW/MPH Intern with the County of San Diego, Behavioral Health Services

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

Data analysis showed that the average score on the domains of Satisfaction and Participation in Treatment Planning in the Adult Consumer Survey rose by 0.1 from August 2012 (pre-intervention) to August 2013 (4 months into the intervention). 24 completed surveys were received in 2012 and 18 were received in 2013. The data on the survey results were not reported in a form in which the results could be examined for statistical significance. However, the small number of completed surveys makes it unlikely that the changes in average scores from 2012 to 2013 could have been calculated to be statistically significant.

In the Adult Consumer Survey, it is interesting to look more closely at the two statements comprising the Participation in Treatment Planning domain. For the statement "I, not staff, decided my treatment goals," the number of respondents who agreed or strongly agreed rose from 70.8% to 81.3% and the average score rose from 4.0 to 4.2, indicating improvement. However, for the statement "I felt comfortable asking questions about my treatment and medication," the number of respondents who agreed or strongly agreed fell from 95.8% to 83.3% and the average score fell from 4.4 to 4.3. This provided feedback so that staff of Southeast Mental Health Clinic would know that it was appropriate to discuss in a staff meeting how they can make clients feel more comfortable asking questions related to their treatment and medication.

According to youth completing the Youth Service Survey, satisfaction was unchanged from August 2012 to August 2013 with 100% of respondents agreeing or strongly agreeing that they were satisfied. The percentage of parents/caregivers agreeing or strongly agreeing that they were satisfied with their child's services fell slightly, from 81.8% to 75%. Given the small number of parents completing the survey (12 in 2012 and 4 in 2013), it is unlikely that those changes could have been calculated to be statistically significant.

On the questions related to Participation in Treatment Planning in the Youth Service Survey, both the surveys completed by parents and youth showed small increases.

Although the Trauma-Informed Care staff survey was conducted in August 2013 (4 months after the intervention began), it provided some information that may be useful for the individuals conducting the training of staff. 12 of 14 staff (85.7%) indicated that they had received training on what trauma-informed care is. This proportion is higher than the 44% of staff system-wide in a 2012 survey who reported they had been trained on what trauma-informed care is. 5 of 14 staff (35.7%) indicated that they had received training on how to integrate trauma-informed care principles. This proportion is similar to the 34% of staff system-wide in a 2012 survey who reported they had been trained on how to integrate trauma-informed care principles. 4 of 14 staff (28.6%) indicated that they had received training on how to ask about trauma and how to respond. This proportion is less than the 50% of staff system-wide in a 2012 survey who reported they had been trained on how to ask about trauma and how to respond.

The results of this analysis may have provided good feedback for the people who are implementing the intervention. As of August 2013, the majority of staff said they had not been trained on how to integrate Trauma-Informed Care principles or how to ask about trauma and how to respond. This provided an indication to program managers to seek out trainings for staff that address these gaps during the remaining 8 months of the intervention after this survey was adminstered.

The "Safe & Secure Environment" Consumer Survey, completed in October 2013, shows that 89% of consumers agreed or strongly agreed with the statement "I feel welcomed at Southeast Mental Health Clinic," 83% agreed or strongly agreed with the statement "The waiting room makes me feel comfortable," and 91% agreed or strongly agreed with the statement "The facility makes me feel comfortable." Although a pre-intervention measurement was not taken, this measurement six months into the intervention shows that the majority of consumers responded positively to the environment at Southeast Mental Health Clinic. Enhancing the environment of the clinic and its waiting room to make consumers more comfortable was one of the action items of the intervention, and this survey provides feedback that these efforts are succeeding.

16. **Present objective data results for each performance indicator. <u>Use Table D and attach supporting data as tables, charts, or graphs.</u>**
Include the raw numbers that serve as numerator and denominator!

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement Achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Adult Consumer Survey Scores – Southeast Clinic: Satisfaction Domain (overall)	August 2012	Average Score: 4.3	Percentage analysis cannot be applied to ordinal data such as scores on a Likert scale. However, the goal is for scores on this domain to increase, indicating improved satisfaction.	April 2013-April 2014	August 2013	Average Score: 4.4	Percentage analysis cannot be applied to ordinal data such as scores on a Likert scale. However, average satisfaction levels improved.
Adult Consumer Survey Scores – Southeast Clinic: Participation in Treatment Planning Domain (overall)	August 2012	Average Score: 4.2	Percentage analysis cannot be applied to ordinal data such as scores on a Likert scale. However, the goal is for scores on this domain to increase, indicating increased participation.	April 2013-April 2014	August 2013	Average Score: 4.3	Percentage analysis cannot be applied to ordinal data such as scores on a Likert scale. However, average participation levels increased.
Youth Service Survey scores: Southeast Clinic:	August 2012	81.8% agree / strongly agree with the statement:	Increase (no specific percentage	April 2013-April 2014	August 2013	75% agree / strongly agree with the statement: “Overall, I	The percentage of parents who

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement Achieved
Family Form (Completed by Parent/Caregiver): Satisfaction		"Overall, I am satisfied with the services my child received."	goal set)			am satisfied with the services my child received."	responded to the survey and said they were satisfied with their child's services decreased slightly.
Youth Service Survey scores: Southeast Clinic: Youth Form (Completed by Youth): Satisfaction	August 2012	100% agree / strongly agree with the statement: "Overall, I am satisfied with the services my child received."	It is not possible to score higher on this measure. The goal is to maintain this score.	April 2013-April 2014	August 2013	100% agree / strongly agree with the statement: "Overall, I am satisfied with the services my child received."	Maintained 100% score, indicating all respondents felt satisfied overall.
Youth Service Survey scores: Southeast Clinic: Family Form (Completed by Parent/Caregiver): Participation in Treatment Planning	August 2012	(Percentage of clients who agree with the statement "I helped to choose my child's services" + Percentage of clients who agree with the statement "I helped to choose my child's treatment goals" + Percentage of clients who agree with the statement "I participated in my child's treatment") divided by 3 (for 3 questions) = 90.33%	Increase (no specific percentage goal set)	April 2013-April 2014	August 2013	(Percentage of clients who agree with the statement "I helped to choose my child's services" + Percentage of clients who agree with the statement "I helped to choose my child's treatment goals" + Percentage of clients who agree with the statement "I participated in my child's treatment") divided by 3 (for 3 questions) = 91.67%	Increase of 1.33 percentage points
Youth Service Survey scores:	August 2012	(Percentage of clients who agree with the statement	Increase (no specific percentage	April 2013-April 2014	August 2013	(Percentage of clients who agree with the statement "I	Increase of 5 percentage points.

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement Achieved
Southeast Clinic: Youth Form (Completed by Youth): Participation in Treatment Planning		"I helped to choose my services" + Percentage of clients who agree with the statement "I helped to choose my treatment goals" + Percentage of clients who agree with the statement "I participated in my treatment") divided by 3 (for 3 questions) = 86.66%	goal set)			helped to choose my services" + Percentage of clients who agree with the statement "I helped to choose my treatment goals" + Percentage of clients who agree with the statement "I participated in my treatment") divided by 3 (for 3 questions) = 91.67%	
Staff Trauma-Informed Self Assessment	August 2013	85.7% said training has included "What is Trauma Informed Care," 35.7% said training has included, "How to apply and integrate Trauma Informed Care," and 28.6% said training has included, "How to ask about trauma and know how to respond if disclosure is made."	Increase (no specific percentage goal set)	April 2013-April 2014	April 2014	Not available yet	Not available yet
Safe and Secure Environment Consumer Survey	October 2013	89% agreed or strongly agreed to: "I feel welcomed at Southeast Mental Health Center." 83% agreed or strongly agreed to: "The waiting room makes me feel	Increase (no specific percentage goal set)	April 2013-April 2014	April 2014	Not available yet	Not available yet

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement Achieved
		comfortable." 91% agreed or strongly agreed to: "The facility makes me feel comfortable."					

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur. Provide explanation for any analysis occurring less frequently than quarterly. Some activities and outcomes benefit from or require close, routine monitoring.

Collecting survey responses can be a time- and effort-intensive task, both for the individuals or organizations collecting the responses and the consumers or staff filling out the surveys. If an individual is subjected to surveys on a frequent basis, there is a danger of "survey fatigue." This is when individuals become tired of taking surveys and rush through them. They do not pay sufficient attention to the questions, which degrades the quality of the data. Therefore attempting to collect survey data quarterly would create a high risk for survey fatigue, which would degrade data quality. Instead each survey was administered at two time points. The Trauma-Informed Care staff survey and Consumer Satisfaction survey were administered pre-intervention. The "Safe and Secure Environment" and the Consumer Satisfaction surveys were administered mid-intervention. The Trauma-Informed Care staff and "Safe and Secure Environment surveys will be administered post-intervention in April 2014.

The annual consumer surveys provide a useful measure of consumer satisfaction and participation in treatment planning. In addition, the Trauma-Informed Care staff survey provides a pre-intervention snapshot of staff's perception of how well the program's policies are informed by the principles of Trauma-Informed Care.

b. Statistical significance

The data available for this PIP were not collected in a format that allows it to be analyzed for statistical significance.

c. Are there any factors that influence comparability of the initial and repeat measures?

No.

d. Are there any factors that threaten the internal or the external validity?

No.

16. To what extent was the PIP successful? Describe any follow-up activities and their success.

The PIP cannot be judged as successful or not until the intervention has been completed, which will occur in April 2014. After the completion of the intervention, two follow-up assessments will be taken – the Trauma-Informed Care staff survey and the "Safe & Secure Environment" Consumer Survey. These follow-up assessments will provide invaluable data on the effect of the intervention.

The data currently available suggest that we have reason to be optimistic that the intervention will be successful in the goals of increasing staff trauma informed care competencies and consumer satisfaction. Results of the consumer satisfaction survey (adult) indicate higher levels of satisfaction and participation in treatment planning after only 4 months of the 12-month intervention. Results of the "Safe & Secure Environment" Consumer Survey conducted after 6 months of the intervention indicate that the majority of clients feel welcomed and comfortable at the Southeast Mental Health Clinic. Results of the Trauma-Informed Care staff survey indicate that the majority of staff has been trained on what trauma-informed care is. Given these preliminary data, it is likely that the post-intervention data will show that the intervention succeeded in achieving its goals.

Additionally, there is much qualitative evidence that suggests that this PIP is successful. There has been feedback from both staff and clients that consumer satisfaction is increasing as a result of more care being given to recognizing the effect of trauma and making efforts to make consumers feel safe and comfortable. Twice-a-month meetings have been held in which training is conducted and staff provide feedback and discuss the results of their attention to trauma-informed care. One of the important innovations from these meetings is that not only clinicians receive specialized training, but also administrative staff and security. These trainings recognize that the first impressions made on clients come from the security staff at the door and from administrative staff such as receptionists. All staff have an important role to play in making clients feel comfortable and welcomed, before the clients meet the clinicians who provide direct care. It is important to note that there is a great deal of evidence from day-to-day experiences at Southeast Mental Health Clinic that suggests the intervention is succeeding, even though the experiences do not produce quantifiable data.

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

The consumer satisfaction survey which is performed every August used the same questions in 2012 (pre-intervention) and 2013 (mid-intervention), and will use the same questions in 2014 (post-intervention). The Trauma-Informed Care staff survey that will be used post-intervention in April will use the same questions as the earlier survey, and the post-intervention "Safe & Secure Environment" Consumer Survey will also use the same questions as in the earlier survey. No modifications are planned.

20. Does data analysis demonstrate an improvement in processes or client outcomes?

Data analysis demonstrates an improvement in the areas of client satisfaction and participation in treatment planning between August 2012 (pre-intervention) and August 2013 (mid-intervention). An updated PIP will be submitted to APS after the analysis of the post survey results once the data is received in April 2014.

21. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

Face validity is a term used to describe whether a test, measurement, or statistic measures the concept that is supposed to be measured. The goal of this intervention is to increase staff trauma informed care competencies and consumer satisfaction. The Satisfaction domain of the annual consumer surveys is a measurement of consumer satisfaction with high face validity, because it measures the domain that the intervention seeks to improve. The Participation in Treatment Planning domain of the annual consumer surveys was chosen to be tracked in this PIP because consumer participation in treatment planning is an important element of the principles of trauma-informed care. The Trauma-Informed Care staff survey has a domain of Consumer Involvement in which staff is asked whether they support consumers in setting their own goals. The Participation in Treatment Planning domain has a high face validity because it measures an important trauma informed care competency, from the perspective of the consumer.

While it is not statistically possible to prove what causes an increase in survey scores, there is ample anecdotal evidence to suggest that consumer satisfaction is increasing as a result of the intervention. This evidence comes in the form of feedback from both staff and clients that consumer satisfaction is increasing as a result of more care being given to recognizing the effect of trauma and making efforts to make consumers feel safe and comfortable.

22. Describe statistical evidence that supports that the improvement is true improvement.

The domains of Satisfaction and Participation in Treatment Planning on the consumer surveys had shown an increase of +0.1 from pre-intervention (August 2012) to mid-intervention (August 2013). It cannot be statistically proven that this increase is a result of the intervention. More statistical data will be available after the intervention is completed in April 2014, at which time a post-intervention "Safe & Secure Environment" Consumer Survey and Trauma-Informed Care staff survey will be conducted.

23. Was the improvement sustained over repeated measurements over comparable time periods? Or, what is the plan for monitoring and sustaining improvement?

A new contract has been established between the County of San Diego and Dr. Dawn Griffith to implement the recommendations of her 2012 Trauma-Informed Care Behavioral Health Assessment. This contract is evidence of the County of San Diego's continuing commitment to use the principles of trauma-informed care to improve the quality of services, wellness of staff, and satisfaction of Behavioral Health Services clients throughout the systems of care. After the end of the official intervention, the staff at Southeast Mental Health Clinic will continue to discuss their experiences with clients in the context of the principles of trauma-informed care.

List of Attachments

Attachment A: Trauma Informed Care Staff Assessment

Attachment B: Client Survey Report

Attachment C: Trauma Informed Care Core Implementation Team Meeting Minutes

Attachment D: Trauma Informed Care Timeline

Attachment A: Trauma Informed Care Staff Assessment

Question	% Disagree	% Agree	% Don't know
The program and/or agency provides opportunities for staff input into program practices (e.g., when and where intakes occur) and policies (e.g., decisions about funding -- when a service has to end due to the expiration of funding)	64%	21%	0%
A universal trauma-screening tool is provided to all consumers	57%	14%	29%
Consumers are asked where they want to conduct the intake	57%	29%	7%
Language on self-care is written into personal goals of staff members	57%	36%	7%
The program involves staff in its review of policies.	57%	36%	7%
The program involves consumers in its review of policies.	43%	21%	36%
Staff members have regular team meetings where topics of trauma are discussed (e.g., debriefing of traumatic incidents)	57%	43%	0%
Staff at all levels receive training and education on trauma and the impacts of trauma	57%	43%	0%
Staff training is mandatory and during your shift hours	57%	43%	0%
The program has developed a de-escalation policy that minimizes the possibility of retraumatization	36%	29%	36%

The program has a written commitment to hire staff who have lived experiences e.g., experiences of mental health issues, trauma, people in recovery, etc)	29%	29%	43%
Staff members receive individual supervision and support from supervisor	43%	50%	0%
Staff members have reviewed existing instruments to see the range of possible screening tools	36%	50%	14%
Written policies are established based on an understanding of the impact of trauma on consumers and staff.	29%	43%	29%
The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of the consumers and their staff	29%	36%	36%
Former consumers are hired at all levels of the program (e.g., as both professionals and peer/family-support partners)	29%	43%	29%
The program/agency has a shared philosophy and approach for trauma informed care.	36%	57%	7%
Staff members have access to existing instruments to see the range of possible screening tools	29%	64%	7%
A list of triggers are created for each consumer along with strategies to address (i.e., situations that are stressful or overwhelming and remind the consumer of past traumatic experiences)	29%	57%	0%
Consumers are asked about the least intrusive ways for staff to check in on them and their progress	21%	64%	0%
Part of the supervision is used to help staff understand their own stress responses and coping strategies	29%	71%	0%
Outside agencies with expertise in cultural competence provide on-going training and consultation	21%	79%	0%

Before leaving the program, consumers and staff develop a plan to address future service needs related to trauma for them and their families	14%	71%	0%
The program/agency has a written statement that includes a commitment to understanding trauma and engaging in trauma-informed practices	14%	64%	21%
The program/agency recognize the trauma associated with staff's exposure to other people's trauma	14%	71%	14%
The program/agency provides consumers with opportunities to make suggestions about ways to improve/change the physical space	14%	79%	7%
Staff members have access to literature and resources on evidence informed and promising practices	14%	79%	7%
Staff members ask consumers for their definitions of physical and emotional safety	14%	64%	14%
Within Trauma Informed Care, do you believe that you can hold people accountable AND be Trauma Informed?	0%	64%	36%
The program/agency informs consumers about why questions are being asked	14%	79%	0%
The intake (e.g., i.e., the process of signing release and billing forms) is conducted when the consumer is ready (i.e., they are asked what they need first, to talk with someone or process their participation in the program)	7%	71%	14%
Consumers are informed about how the program responds to personal crises (e.g., suicidal statements, violent behavior).	7%	79%	0%
Throughout the assessment process, the program checks in with consumers about how they are doing (e.g., asking if they would like a break, water, etc.)	7%	71%	7%

The program/agency ensures services are coordinated (mental health and substance programs are concurrent and integrated)	7%	86%	0%
Consumers work collaboratively and within a shared decision making paradigm with staff to create written, individualized safety plans for them and their family	7%	86%	0%
Before leaving the program, consumers and staff develop a plan to address potential safety issues	0%	86%	0%
The environment outside the program/agency is clean, welcoming and well lit	7%	93%	0%
There are private, confidential spaces available to conduct intake assessments	14%	86%	0%
The program coordinates on-going communication between all service agencies associated with the consumer's service plan	0%	100%	0%
Supervisors, Directors and Administrators support the need for trauma informed care.	7%	93%	0%
Consumer rights are posted in places that are visible	0%	100%	0%
Staff shows acceptance for personal religious or spiritual practices	7%	86%	7%
Consumer goals are reviewed and updated regularly	0%	93%	0%
Staff supports consumers in setting their own goals	0%	86%	0%

Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.)	0%	93%	0%
The program/agency incorporates consumer-friendly decorations and materials	0%	100%	0%

The Trauma Informed Care staff assessment has 46 questions, and 14 people responded to the survey. Of the 46 questions, 9 had a plurality or majority of negative (disagree) responses and 30 had a majority of positive (agree) responses. Additionally, there were 7 questions on which the respondents were ambivalent – there was no clear majority response between "agree," "disagree," "don't know," or "not applicable," or 50% of respondents agreed but a large number disagree or didn't know the answer.

It should also be noted that there were 8 questions to which a high number of respondents (29% to 43%) answered "I don't know."

In the attached document, the questions are ranked in order from most negative responses to most positive. In Column J is the "% of respondents who disagree," and those questions to which a high number of respondents disagreed are highlighted in RED. In Column K is the "% of respondents who agree;" those questions to which a high number of respondents agreed are highlighted in GREEN, and those questions that were answered ambivalently are highlighted in ORANGE. In Column L is the "% of respondents who don't know;" those questions with a high number who don't know are highlighted in YELLOW.

To summarize:

RED: Negative / Disagree
ORANGE: Ambivalent (no clear majority agree or disagree)
YELLOW: Don't know
GREEN: Positive / Agree

Attachment B: Client Survey Report

Southeast Behavioral Health Center "Safe & Secure Environment" Consumer Survey

November 2013

County of San Diego – Behavioral Health Services

Introduction

Southeast Behavioral Health Center (SEBHC) administered surveys to elicit feedback regarding the clinic's environment. The purpose was to assess how the environment of the clinic contributed to the comfort levels of consumers during a recent visit. SEBHC is part of a nation-wide learning collaborative initiative with the National Council for Community Behavioral Healthcare. SEBHC is working with the National Council to promote Trauma Informed Care throughout the clinic. The National Council has identified seven domains, or areas of focus to further develop and fully implement Trauma Informed principles into everyday practice and agency policy. The current survey evaluated the clinic's progress in domain five, "Creating Safe and Secure Environments." Prior to the survey, the clinic implemented changes to create a therapeutic atmosphere for visitors. This included adding plants and consumer artwork as well as displaying welcoming messages on paper clouds throughout the clinic. Staff provided surveys to voluntary Adult/Older Adult and Children, Youth, and Family consumers. The survey was available in English and Spanish. Parents and other adults who accompanied child consumers under the age of 11 or youth unable to complete the surveys responded on their behalf. The clinic collected 57 surveys between October 14, 2013 and October 25, 2013.

Results

There were 57 surveys submitted between October 14th-25th, 2013. Of those submitted, 54 were complete and 19 consumers provided narrative feedback.

Question	Strongly Disagree	% Strongly Disagree	Disagree	% Disagree	Agree	% Agree	Strongly Agree	% Strongly Agree	Do Not Know	% Do Not Know
I feel welcomed at Southeast Mental Health Center	3	6%	0	0%	19	35%	29	54%	3	6%
The waiting room makes me feel comfortable	4	7%	2	4%	24	44%	21	39%	3	6%
The facility makes me feel comfortable.	3	6%	1	2%	27	50%	22	41%	1	2%

Comments

- "My counselor is really helping me with my issues. I feel like she really cares. It is really nice to have someone in my corner helping me."
- "Just want to feel better."
- "I feel supported when I arrive. I don't know what I would do if I wasn't welcome here. Thanks for everything."
- "The service is exceptional and the employees have a great passion for the services they render."
- "Games for children, programs for children on television"
- "I think I'm doing well because I feel like a family."

Conclusions/Next Steps

Southeast Behavioral Health Center will provide results to the nation-wide Trauma Informed Care Learning Community as part of the year-long pilot project to enhance the use of Trauma Informed Systems and Services throughout Behavioral Health

Services. In order to assess the impact of further changes, a follow-up survey will be administered April 2014, one year after joining the learning community.

Attachment C: Trauma Informed Care CIT Meeting Minutes

Minutes from TIC (Trauma Informed Care meeting) 3/06/2013

Present: Greg Watson (PM), Anne Fitzgerald (PM), Aldo Vereo (front staff), Berenice Badillo (Clinician), Louise Zavala (clinician), Patty Fulgencio and Florence Linderman (consumers), Juan Estrada (Harmonium/TAY).

1. Introductions and ground rules to provide safety and validation to all participants. Anne F. distributed a handout, "How to Manage Trauma" published by the National Council. Greg W. read "CIT Meetings" published by the National Council for Community Behavioral Healthcare and it was used as the agenda.

2. Discussion regarding purpose of TIC and meetings, clarification regarding the role in implementation meetings, need for continued education and communication to all employees. County Vision statement explored and discussion regarding vision statement that defines movement towards TIC. Discussion regarding TIC champions and complete integration of identified need for TIC implementation. Las Vegas conference discussed (purpose, logistics, travel and accommodations.)

3. Consumers identify need which deal with desire for increased engagement by front staff (eye contact, acknowledging presence and smiling). Consumers share their concerns of feeling separated from staff and experience of coming to the clinic for the first time. Exploring who staff is "working for" by running percentages of diagnosis (i.e. number of PTSD, Bipolar clients, etc.). Increased connection to community and possible connection with Betsey Knight in County case management who is the lead in trauma response team as well as connecting with Pam Hanson at San Diego Center for children. Topics touched upon include exploring a questionnaire that may be utilized to assess consumer with trauma issues. Education and exploration if this may be triggering vs needed for clinicians and front staff. Aesthetics and TIC environment in waiting area and in offices explored. The representation and voice of the consumers identified through posters, stories and client artwork to alleviate fear of the unknown when engaging in services. A stress on more EMDR training beside basic training to further provide consumers with effective modalities to address trauma.

4. SEMH TIC Vision/Mission Statement: Southeast Mental Health Center, in partnership with our communities, strives to make people's lives safe, healthy and self-sufficient by providing quality trauma informed behavioral health services.

5. Agenda for next meeting explored with all attendees. Further discussion with consumers and food for thought: In what way would the organization change, will the relationship between the CLT and staff change? What is the future of SEMH? What could we implement now? Possible limitations (funding, taxpayer function etc.). What can we strive for? Exploring who else could be involved (family from children's department). Greg W. said he would forward, via email, the following handouts: Domains, CIT Meetings, TIC Implementation Process and a web seminar that took place last month, for those who had not received these previously. Next meeting scheduled for Thursday, March 21 at 11:00 AM.

Meeting adjourned

Minutes from TIC (Trauma Informed Care meeting) 3/21/2013

Present: Greg Watson (PM), Ann Fitzgerald (PM), Aldo Vereo (front staff), Berenice Badillo (Clinician), Louise Zavala (clinician), Juan Estrada, (Harmonium), Florence Linderman (consumer) and Terry Maxson (PM for Harmonium).

Absent: Patty Fulgencio

Minutes taken by: Aldo Vereo

1. We talked about forwarding article about the group in 43st that uses TIC with community members impacted by violence. Information on how to connect our efforts on Trauma Informed Care.
2. Anne and Greg would attend the county wide trauma informed committee to avoid duplicating efforts.
3. Fix our brochure to include that we are a clinic that is Trauma Informed Care, and insure that the wording in the brochure reflects a trauma informed orientation.
4. Greg: There are many domains that we can tackle.
5. We talked about implementing changes inside the front office.
6. Combine efforts with clinic next door. How to deal with mentally ill individuals. Some training with staff next door.
7. Terry: 2 Ideas. How to infuse first responders. How to approach as a public issue, how the community should respond.
8. Greg: We need to approach the steering committee to implement county wide initiatives.
9. Berenice: Start with how to make clinic friendlier to clients. Talk about adding ornaments (Clouds) with messages from clients. She will bring a prototype to the next meeting.
10. Greg: We also need the participation of individuals receiving services to be integrated in the process. Have those individuals participate in the process to decorate the office and or Lobby.
11. Berenice: Talked about maybe Murals, or art pieces that can be moved. Aldo discussed starting first in clinician's office to reflect TIC. Explored resources for art supplies.
12. Florence noted issues with the lobby. Not enough room for someone already anxious. It was agreed that we would discuss with San Ysidro Health care, if we could direct people that they could sit in the large hallway if they did not feel comfortable in the small waiting area. In addition, issues of making the space warmer, representing the community, etc. to be explored. The idea of plants to warm the space to be explored.
13. Louise had suggested changes to the "Chateau" (trailer). This included measures to reduce noise from the waiting area and between offices. It was agreed that Greg and Anne would approach HHSA Facilities to see what could be done to decrease the noise in that area.
14. Questions regarding how TIC will provide training for therapists and doctors to do their job more effectively.
15. Florence agreed to email information about Las Vegas to the group.

Minutes from TIC (Trauma Informed Care meeting) April 3, 2013

Attendees: Greg Watson (PM), Anne Fitzgerald (PM), Berenice Badillo (Clinician), Louise Zavala (Clinician), Aldo Vereo (Front desk staff), Juan Estrada (Harmonium), Terry Maxson (PM for Harmonium), and Florence Linderman (Consumer)

Absent: Patty Fulgencio, Family and Youth Roundtable (FYRT Org.)

Minutes taken by Florence Linderman

1. Greg asked the group if any additions or changes needed to be made to the last meeting's minutes. Florence stated that the date needed to be corrected to reflect, "March 21, 2013." No further input was made. Greg will make the correction and forward to Sabrina Marshall.

2. Anne read a book to the group entitled A Terrible Thing Happened by Margaret Holmes. Both, the reading and the book, were well received. Anne said that she would like to get a copy (copies)??? and Greg gave her input as to how to pay for it on Amazon.

3. Greg said he would like to return to the subject of the reception/waiting room area. He said that he has a meeting scheduled with the person who provides and maintains the plants at the Rosecrans facility. He will ask for a bid for the reception area. It is his understanding that included in the purchase of the plants is the maintenance, upkeep, and replacement of any plants if necessary.

Greg talked to Chris Jenkin, of Comprehensive Health, regarding SEMH clients using the chairs out in the hallway. Chris said he didn't have any problem with the hallway, and the chairs, being used by "our" clients. Greg said that a sign needed to be made. The sign will let the clients know they can use the hallway while they wait for their appointment. Aldo agreed to make the sign.

4. Berenice made a presentation to us from her art therapy group. The art project is a three-layered cloud. Each cloud hangs from its own string, which once installed, hangs from the ceiling. The clouds are decorated and include inspirations that each individual client finds meaningful. Berenice has a group of eight clients right now, in the art therapy group, and the group is open to additional clients joining. The art group is very excited about displaying their art within the clinic and there was mention that an opening, including a reception, would take place once the clouds are installed. A date has not been set for the opening/reception so as to not rush or cause anxiety to the clients involved in this endeavor.

Greg said he will check with facilities regarding the installation of the art once the group has completed their clouds. Greg suggested inviting the San Ysidiro clinic to the opening; that attending the opening might give them ideas as to what they can do to help create a different setting for their clients.

5. Greg mentioned the television set in the reception area. He suggested while we're at the convention in Las Vegas we might want to take notice of video's that are available for purchase. Notice any titles or themes that are being used in facilities that are fully TIC integrated. We may want to make purchases of this nature in the near future. Music was mentioned as an alternative to having the television playing.

6. Louise asked if she could discuss "The Chateau" (a modular trailer) and the issues of privacy for clinician/patient while people are waiting nearby the office doors or talking loud enough to interrupt sessions. Louise did not want to encourage creating a waiting area in the Chateau due to the space limitations. In a perfect scenario, all family members of a client would wait in the reception area where Aldo is located, but parents want to be close to their child so this need has to be considered and worked out. Perhaps solutions will be presented at the conference.

Greg mentioned that the facilities employees will begin to work on the issue of noise reduction with the ceiling panels. If once this work is completed, and other measures need to be taken, Greg will address the next step.

Greg asked that an agenda item be marked for our next meeting: Ask for Patty's input as to childcare while the parent is receiving services and vice versa. How do we best address the issue of children who are left, without an adult, to sit and wait in the reception area?

7. Greg wanted to make all the members aware that Juan would not be attending any of the conference in Las Vegas. Therefore, it is up to each of the members to bring back any printed materials they are provided, make a copy of notes; make sure Juan does not feel left out of the loop because he wasn't provided the opportunity to attend.

Greg told us he would be attending the conference on Sunday and Monday; Anne will be attending Tuesday through Thursday; Berenice, Louise, Aldo, Florence and Patty will be attending Wednesday and Thursday. Florence mentioned that she was told ground transportation would be provided for her. Thus, the County employees will have to pay for the taxi rides to and from the convention hotel (because they will be reimbursed for this expense.)

8. Louise mentioned the Bilateral Safety Corridor Coalition (human trafficking). She is attending their meeting next week, April 9th from 10 am to Noon. She invited the members to join her and/or to attend their next scheduled meeting.

9. **Our next meeting is set: April 24th, at 11 am.**

Meeting adjourned at 12:00 pm.

Minutes from TIC (Trauma Informed Care meeting): April 24, 2013

Present: Greg Watson, Anne Fitzgerald, Berenice Badillo, Louise Zavala, Aldo Vereo, and Juan Estrada

Absent: Florence Linderman and Patricia Fulgencio

1. With this being the first meeting since the training in Las Vegas, there was a discussion regarding what is "Trauma Informed Care". Some of the ideas discussed included;

- "Catering to client needs"
- The look and feel of the environment
- The need for consumer involvement
- Clinician "Trauma/Compassion Fatigue"
- The need for support and ongoing training for all staff

2. There was then discussion regarding the goals of the Core Implementation Team. The discussion included several items that had already been identified: art projects, looking into getting plants, finding more space for individuals to wait for appointments, and having a meeting with various staff including security guards, San Ysidro Health Clinic staff and Maintenance personnel. It was agreed that having all clinic staff complete the "Organizational Self-Assessment" might help to identify the domains to focus on. This prompted discussion about who all should be involved in the Core Implementation Team. After much discussion regarding various groups that could be involved, it was agreed that the Team focus is on the services at Southeast, and so inclusion should be considered based on if it would help in this service delivery, or if it would be outside of that focus area. Some suggestions included a youth representative who had received services at Southeast previously, or someone that received services elsewhere.

3. There was a question about if we were one team with one consultant, how would information specific to children be obtained. It was discussed that there had been a recommendation from the national committee for there to be one team and that it made the most sense for the alignment to be with adult providers. It was agreed that specific information could be obtained by other learning community programs that may be more specific to children, if there was something needed.

4. Greg and Anne presented information from the Steering Committee meeting on April 23. The team was informed that a QI representative would be attending some of the meetings to help with the development of measurable goals and tools for measuring progress. Greg and Anne informed the committee that Piedad Garcia, Assistant Deputy Director, has graciously offered to prepare a Carne Asada meal for the Core Implementation Team and all staff of the Southeast Center, with others bringing the other food and paper goods etc. That would be with members of the Steering Committee. It is likely to be in late June with the date still being finalized.

Other items discussed included that Greg would be attending the county wide Trauma Informed Care Council, and seeing how we can link our efforts with other programs developing TIC in the county. Greg will also obtain bids for plants at the Southeast Center and present these bids to administration. Sound proofing for the trailer is still being explored.

We will explore possible materials that would help with staff self-care and compassion fatigue.

Louise Zavala attended the Bilateral Safety Corridor Coalition meeting on 4/9/13, which focused on Human Trafficking. Louise Zavala suggested that members of Core Team and/or Champions should continue to participate at various meetings throughout the county.

The next Core Implementation Team meeting is scheduled for **Wednesday, May 8 at 11:00 AM**.

Minutes from TIC (Trauma Informed Care meeting): May 8, 2013

Next Meeting: 5/22/13, 11 am to 12:30 pm

Present: Greg Watson, Anne Fitzgerald, Berenice Badillo, Louise Zavala, Aldo Vereo, Patricia Fulgencio, Terry Maxson and Juan Estrada

Absent: Florence Linderman

1. Greg will request for alternative dates for a Small Group Cohort Call with Linda Ligenza. Dates that were suggested by National Council Committee were not conducive to any of the Core Team's schedules.

2. Virginia West will be attending 5/22/13 Core Meeting.

3. Louise offered to show the "Paradigm Shift" video to both security guards.

4. Greg has received three different bids for plants and maintenance of the plants.

5. Berenice art project with the clouds is pending due to electrical and carpeting projects. Greg has taken before pictures of the waiting area and hallways of the clinic to present as a slideshow for future presentations on Core Team implementation of TIC at South East Behavioral Health Clinic (SEBHC).

6. There was follow up discussion about what is shown on television in the waiting area. Louise suggested videos from It's Up 2 You San Diego website. Aldo & Patty also suggested DVDs or others videos, such as nutritional shows. Aldo will work on connecting internet to T.V.

7. Ongoing discussion for administrative assistants. Anne will check on BHETA to see if there are

upcoming trainings for administrative assistants.

8. Aldo requested that staff be mindful of conversations in the administrative assistant area. Aldo

emphasized importance of self-regulation and to role model this for clients.

9. Greg stressed importance of making small changes and Anne reminded staff about compassion fatigue.

10. Patty will follow up on finding a representative for the Children/Adolescent program at Core Team meetings. Louise suggested that it could be a young adult or parent who is not currently receiving treatment from SEBHC.

11. Greg will review adult brochure and asking feedback from Core Team.

12. On June 26, 2013 from 11 am to 2 pm, SEBHC will be closed to allow all staff and Core Team to attend Carne Asada potluck at the Camino Office. Signs will be posted at SEBHC a week before June 26. Greg will request that Sabrena Marshall send an email with a sign up list for the potluck.

Minutes from TIC (Trauma Informed Care meeting) May 22, 2013

Present: Greg Watson, Terry Maxson, Aldo Vereo, Juan Estrada, Anne Fitzgerald, Louise Zavala, and Berenice Badillo.
Absent: Florence Linderman and Patti Fulgencio.

Next meeting June 5, 2013 at 11:00 AM

1. The issue of Screening and Assessment tools was reviewed. One such tool has been sent to staff by County Admin. The importance that such an instrument not trigger significant issues of privacy, or cause intrusive memories trauma to surface, were discussed. Greg stated that there is an administrative team reviewing the instrument. The CIT agreed that an organized feedback from our team needs to go to the Steering Comm. Anne and Greg will work on this.
2. Greg brought up the TLC Webinar Schedule. These are optional and cover many topics.
3. An Inpatient/Residential Tx. Center for children in Pasadena is seeking ways to linkage with other programs that are new to the Trauma Informed Community. There may be an opportunity for site visits and an interchange of information about what each organization has accomplished so far.
4. Louise Zavala suggested that some of us tour the S D Center for Children and the New Alternatives program on the ESU campus in Chula Vista. Both programs have graduated from the Learning Community for trauma informed care.
5. The Cloud Project that Berenice is heading is on hold until June due to lighting and carpet replacement in the clinic.
6. The Adult Program Brochure has been changed to include the new Mission Statement created by this CORE Team. This will be distributed to all members of the Team and the Steering Comm.
7. Three proposals for plants to be placed in the waiting room and hall have been reviewed by Admin. Our staff has been notified that the purchase of plants is approved. Maintenance of the plants will be the responsibility of the clinic. Alternatives to lower the time and knowledge needed to do this were discussed. Greg will get back to the plant company to ask which plants might be the lowest maintenance.
8. Aldo requests that the chairs in the waiting room be replaced as they are looking shabby. He and Anne will explore this.
9. Follow up conversation about connecting internet to T.V. in waiting room. Options are still being explored.
10. Aldo will speak with both the Security Guards about their approach to clients to reinforce the positive things they do routinely and to explore what areas of their behavior might be altered so as to be more trauma informed. As Louise organized for them to watch the "Trauma Lens" video last week, their understanding of the topic has been increased.
11. Louise will follow up with Patti F. about locating a family representative for our CORE Team. We hope to increase our consumer representation.

Minutes from TIC (Trauma Informed Care meeting) June 20, 2013.

Present: Greg Watson, Anne Fitzgerald, Berenice Badillo, Aldo Vereo, Terry Maxson and Juan Estrada.

Absent: Louise Zavala, Samantha Lea

The initial discussion was regarding our focused efforts on Domain 5, "Create Safe and Secure Environments. Updates included;

1. Updates on the Art Project. We have the project on hold until we get the new carpet installed. It was determined that there is not a way to allow for playing videos from computer links in the center's wait area, so it was agreed that DVD's would be necessary to provide positive messages on the wait area television.

Domain 1, Early Screening and Comprehensive Assessment of Trauma. It was agreed that we would review the Delaware Screening Tool. Not everyone had been able to look at it. It was pointed out that there is a section of that tool that refers to anatomy that may be difficult for someone just entering services to discuss or acknowledge. It was agreed that a copy of the tool would be brought in hard copy to the next meeting to review. It was also pointed out that the county wide Trauma Informed Care committee was going to make recommendations regarding screening a screening tool to be embedded in Anasazi. We will continue to review screening tools and make recommendations as to tools that might fit.

Domain 2, Consumer Driven Care and Services. There is a new potential consumer who would like to be a member of the Core Implementation Team. Berenice is familiar with this individual and believes that he has a lot to contribute to the CIT. It was agreed to invite this individual to be part of the team and an invitation will be made to this new member. It was also discussed that we have a card for everyone to sign to thank Florence for the time on the team. Once the card is signed, it will be mailed to Florence.

Everyone was reminded of the Webinar on June 24. It was agreed that while everyone cannot participate in every webinar, they will attempt attend those that most impact their position.

We also confirmed the plans on the Carne Asada meeting for June 26, 2013.

Next Meeting Scheduled for July 3, 2013. Greg will be on vacation that day, so Anne Fitzgerald will facilitate that meeting.

Minutes from TIC (Trauma Informed Care meeting) July 3, 2013

Present: Anne Fitzgerald, Berenice Badillo, Louise Zavala, Juan Estrada.

Absent: Greg Watson, Aldo Vereo, Terry Maxson.

Berenice briefed the team on Art Installation (clouds). Probable date is week July 22nd. Any team member is welcome to assist with installation, with managers' permission.

Anne and Greg presented book about TIC process to program managers.

Anne commented about June 24th webinar. Parent partners facilitated. Two families talked about their experience. "Locals talking with locals".

Anne and Araceli and Louise attended a Children's System of Care training on TIC, conducted by Kimberly Schultz.

Anne will look into acquiring book, "seeking safety" along with Gregg. This could be start of creating a TIC library, materials and resources.

Discussion about importance of teaching about positive side of affection ("holding ") by clinicians and relationship with TIC.

Also discussed about ACE Survey and trauma and the brain, domestic violence, teen pregnancy, physical health, drug use.

Louise: more discussion on education for parents on trauma effects on children and clinicians on how to administer ACE Survey to parents.

Berenice: process of increasing therapy steps with clients, from 1st contact, to provide more tools, information.

Anne presented "how to manage trauma" booklet. May be useful to clinicians.

Anne: change the wording on how to ask trauma ten questions tool.

Louise: include FYP's (Harmonium) to know ACE Survey, tools, etc.; assist clients with ACE Survey.

Tools discussed: Trauma checklist Adult. Delaware checklist.

Discussion about how QA plans to incorporate, develop, TIC into BHA and repercussions on user/clinicians. QA expects feedback from this team.

Discussed about incorporating all pertinent staff to the TIC process.

Louise: Recommended a documentary film that won an Academy Award entitled "Bully."

http://www.youtube.com/watch?v=W1g9RV9OKhg

Positive videos already running on TV at waiting room. Is there a video schedule?

Patty not with FYRT anymore. Need to look for replacement.

Consumer rep maybe joining in at next meeting.

Trauma Informed Care Core Implementation Meeting
July 18, 2013
11am - 12:30pm

Present: Berenice Badillo, Nathaniel Gilbert, Mario Martinez, Jenelle Singer, Louise Zavala, Greg Watson

Absent: Juan Estrada, Anne Fitzgerald, Terry Maxson, Aldo Vereo

Next Meeting on July 31, 2013 at 11am and every other Wednesday at 11 am.

1. Introductions of new members & team encouraged members to voice their thoughts and opinions. Greg welcomed Mario to sit in with staff member for any future webinars.
    a. Nathaniel Gilbert – Family Youth Roundtable/ Community Engagement Program
    b. Mario Martinez- Adult Consumer Representative
    c. Jenelle Singer – QI department
2. **Update on Art Project:**
    a. Installation of consumer art targeted for end of this month with Art exhibit targeted date sometime in August.
    b. Mario stated that "I am able to express myself through art & discovering my inner self."
3. **Plants**
    a. Team chose Plant Pros for installation & materials
    b. Cost $562.68
4. **QI tool for consumers**
    a. Jenelle passed out copies of:
        i. Adult Consumer Survey Scores - 8/12 for SE Clinic
        ii. YSS Results (Completed by Youth) for 8/12 for SE Clinic, subunit 2130 & 2133
        iii. Consumer Survey
            1. Mario recommended Aldo V. to administer surveys to consumers in waiting room
    b. Jenelle will email revised copies to allow for distribution before, during and after Art Exhibit.
5. **Screening Instruments for TIC**
    a. Greg sent QA ACES & Delaware tools
    b. Tabitha responded for TIC Core Team to make recommendations.

c. Louise suggested that Anne F. call New Alternatives and San Diego Center for Children to follow up on what screening tools they are using.
    i. This is will have a one month action plan
    ii. Core Team will receive email of screening tools chosen to be administered.
    iii. Children/Adolescent Program will administer suggested screening tools.
    iv. Feedback from Children/Adolescent Program will be presented to Core Team.

Trauma Informed Care: Core Implementation Team Meeting Minutes – July 31st 2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Nathaniel Gilbert, Mario Martinez, Jenelle Singer, Louise Zavala, Greg Watson, Juan Estrada, Anne Fitzgerald, Terry Maxson, Aldo Vereo *Absent:* none
Webinar Recap and Discussion *(Domain 3: Workforce Engagement)*	• Discussed general themes that were presented in the webinar. (How workforce engagement principles are infused into the community) • Importance of training all staff and especially Front Desk and Interns on the importance of TIC • TIC should be a part of the interviewing process • What other processes should occur in New Staff Orientation at SEBHC? - New Staff Orientation checklist that includes an overview of TIC Domains, themes, etc. - Roles of: FD Staff, FYPP, Hope Connections, etc. • Discussion of "What About You: A Workbook for Those who Work With Others" - Jenelle will send document to Greg to redistribute to team - Look at implementing some of workbook tools at staff meeting to address Domain 3 - Anne will look through the workbook and identify exercises that are appropriate for staff meetings • Sharing best experiences on a poster board in the lunch room to increase awareness of all the positive things that happen at SEBHC • Brainstormed on how to 'Celebrate TIC Moments' - Create a 'Positive Moments' board in the waiting room for clients and staff to post on - Appreciation Board to combat compassion fatigue, and emphasize strength-based practices - Have the blank forms in clinician office for clients to reflect on 'What makes you smile?' or 'What do you like about SEBHC?'
Art Project/Installation Update	• Installation is in progress, will be completed by end of August • Mario expressed interest in extending the Art Therapy class by 30 minutes
Waiting Room	• Incorporation of conversation when a new client comes to make sure they know they can sit inside the waiting room or outside; whichever they feel most comfortable. • Planet Earth DVD's on order to be played in waiting room in an effort to display neutral television shows

Waiting Room (Cont.)	• Mario suggested that the toys in the waiting room should not make loud noises. It may make people anxious, uncomfortable, etc. Staff will remove high noise toys. • Aldo suggested that the TV have scrolling messages about SEBHC updates, upcoming classes, and helpful tips
Plant Installation Update	• Plants have been ordered • Greg to schedule a time for installation • Aldo will maintain the plants once installed • Aldo to train another staff member to care for plants in his absence
Client Survey Tool - **Domain 5: Create Safe and Secure Environments**	• Client Surveys have been sent to CAO for approval. Target date to implement is the first week of August • Staff surveys for the Adult Team are being finalized. • Jenelle will send to Greg once final for him to distribute electronically to Adult Team.
Adult and Child TIC Screening Tool	• Adults: Greg will recommend Delaware Tool and ACE's • Children: Anne has been researching different potential tools. The one that seems most simple and appropriate is the Primary Care-Post Traumatic Stress Disorder (PC-PTSD). Anne has been in contact with other programs (San Diego Center for Children and New Alternatives) to see which screening tool they have used. • Anne will follow up and continue searching for an appropriate children's screening tool
Upcoming Webinars	**Performance Monitoring Tools & Tips** Wednesday August 7, 2013 2:00-3:30 PM EST Register Here: https://www2.gotomeeting.com/register/572900450 **Domain 4: Evidence-Based and Emerging Best Practices** Monday September 9, 2013 3:00-4:30 PM EST Register Here: https://www2.gotomeeting.com/register/545914778
Next Meeting	August 14th 2013, 11:00am – Southeast Behavioral Health Center

Trauma Informed Care: Core Implementation Team Meeting Minutes – August 14, 2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Mario Martinez, Jenelle Singer, Louise Zavala, Greg Watson, Juan Estrada, Anne Fitzgerald, Aldo Vereo, Liz Miles, Sabrena Marshall, Erin (Intern) *Absent:* Nathaniel Gilbert, Terry Maxson
Performance Monitoring Tool	• Requirements • Presented in the Webinar • Answer as a group • Due date is 10/1/2013 and needs to be submitted again on 3/1/2014
Survey for Staff	• Trauma Informed Care Self-Assessment has been sent out to SECBH staff (Approximately 14 Team Members) • QI will gather the survey results and disseminate when all surveys have been completed • Survey took approximately 15-20 minutes to complete • Survey addresses all areas of TIC, but will also be used to engage the workforce (Domain 3)
Domain 5: Safe and Secure Environmental- Updates/Changes	• Plants have been installed • Clouds have been installed • Noisy toy has been removed → Crayons and coloring book pages will be placed in waiting room • Greg will keep before and after pictures to show changes • Sabrena will find old picture frames from BHS to donate to SECBH for additional art displays • Staff will create an 'Appreciation Board' to encourage and inspire others • Potentially incorporate San Ysidro for seamless TIC environment
Domain 3: Workforce Engagement	• Need to find specific trainings for all and interns to teach about TIC - Ongoing training for EMDR through BHSTEC - Seeking Safety Training - Need to look at State level resources - If day training how will SECBH find coverage for providers? • How to incorporate into the interview process • Combating Compassion Fatigue: Anne will use the 'What About You' Workbook (Dwelling on Days that Made You Want to Come Back) Exercise 3.6 on page 44 with her staff at staff meeting • Potentially offering 30 min yoga classes/guided meditation/stress relief to staff to combat compassion fatigue
Screen Tools Update	• Greg - Delaware/ACE's is the best screening tool to assess trauma in adults

	• SECBH is testing out Adult screening tool • Anne- Sent her screening tool to Katie Astor for review • Final recommendations need to be taken to the Clinical Standards Committee
Other Updates	• Trauma Informed Care – Core Implementation Team from Pasadena (11 people) will be joining us at the next meeting to share best practices, ideas, thoughts, and project progress. • Still waiting for the client survey to be approved by CAO • Louise will be following up with an additional consumer representative to join Core Implementation Team
Tracking Progress	Discussed progress and changes that have occurred since the TIC Project began: • Mission Statement has been revised • Brochure has been updated • New Paint • New Carpet • Plants • Clouds with Client Messages • Children – Art Display • TV Programming – Planet Earth • Removal of Toys that are high volume in the waiting area • Additional seating in the lobby of the building Discussed potential TIC intern
Upcoming Webinars	Domain 4: Evidence-Based and Emerging Best Practices – September 9th 2013 – 12:00pm-1:30pm
Next Meeting	August 28, 2013 – 11:00am – 12:30pm

Trauma Informed Care: Core Implementation Team Meeting Minutes – August 28, 2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Nathaniel Gilbert, Mario Martinez, Jenelle Singer, Louise Zavala, Greg Watson, Juan Estrada, Anne Fitzgerald, Aldo Vereo, Erin Springer *Absent:* none
Performance Monitoring Tool	• Needs to be completed and sent to National Council by October 1. • An updated tool was sent by email and will be used for this task. • The group completion of the Performance Monitoring Tool will be started on Sept. 11 so that if not completed in one meeting, can be finished at next meeting. • Once completed, Greg will Scan and send to National Council
Staff TIC Self-Check surveys	• There were 16 staff to complete surveys • 13 surveys have been completed • Greg to send out another email to encourage staff to complete the survey
Training for staff in Evidence Based TIC Model	• Greg made contact with state trainer for "Seeking Safety" model and found that the cost was about $2000 for a one or two day training. • It is hoped that the Sept. 9 webinar on "Evidence Based Practices" will provide information on some models that may be considered for training.
Screening Tools	• Anne Fitzgerald and the Children's Program Staff have reviewed tools that may be considered. • Anne has forwarded a tool to Child and Adolescent BH Admin. for consideration. • Tools to be presented to Clinical Standards Committee on Sept. 27.
Other Updates	• Louise stated that she had received some positive comments from a parent about changes in the

	seating arrangement in the waiting area. There was also a comment from this individual that they would like to see fewer chairs and more plants. • It was decided that people in wheelchairs can use the space where the vending machine used to be so that they can have space for waiting. • There was discussion regarding the issues with children being left alone in waiting area and a decision made to post signs to not leave children alone unsupervised. • We are still working on the exact type of display for positive comments and what the form should look like. Children's staff and adult art group to develop some ideas for the positive comments display.
Upcoming Webinars	**September 5 – Webinar Bruce Perry on helping children to recover from trauma** **September 9 – Domain 4, "Provision of Trauma-Informed, Evidence-Based and Emerging Best Practices**
Next Meeting	September 11

Trauma Informed Care: Core Implementation Team Meeting Minutes – 9/11/2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Nathaniel Gilbert, Mario Martinez, Jenelle Singer, , Greg Watson, Juan Estrada, Anne Fitzgerald, Terry Maxson, Aldo Vereo, Chris Dionisio, Erin Springer *Absent:* Louise Zavala
	Greg reported on the Steering Committee meeting that he attended 9/10/13.The options for a Trauma Informed Screening Tool were discussed. Common thoughts were "short, simple and easy", and the facilitation of direction to explore any themes of trauma further with potential clients. Also covered were finalizing the Initiative for the "roll out" of TIC to Service Providers County wide. Finally, all Staff training needs, specific to job descriptions, will also be drawn up and prioritized.
	In Staff meetings the Program Managers and Core Team members will ask for feedback about training topics and give this feedback to Erin who will bring the info to Liz Miles.
	Berenice reviewed the fact that there is much breadth and significance in using Art Therapy and EMDR for treating trauma.
	A good part of the meeting was taken up by the first half of the Performance Monitoring Tool, with all attendees providing responses as they wished to.
Upcoming Webinars	
Next Meeting	We., 9/25,2013 at 11:00 AM

Trauma Informed Care: Core Implementation Team Meeting Minutes – 9/25/2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Nathaniel Gilbert, Louise Zavala , Greg Watson, Juan Estrada, , Terry Maxson, Aldo Vereo, Chris Dionisio, Erin Springer *Absent:* Mario Martinez, Jenelle Singer, Anne Fitzgerald
	Greg updated team on meeting with Pasadena group that was a multifaceted agency that includes residential and outpatient. Greg reported that the group gave positive feedback on the progress we have made on Domain 5. Greg reported that group was part of 4 groups in California that where involved in the learning community
Performance Monitoring Tool	The majority of the meeting was used to complete the Performance Monitoring Tool which was completed. To be sent to National Council on September 27, 2013
Miscellaneous discussion and review items.	• Greg encouraged participation in October 7 conference call with our national consultant Linda. Discussion included exploring options to items in performance tool in which we were lacking. • Discussion regarding getting the word out and self-care for staff. Greg reported that self-care assessment tool presented by Berenice Badillo in treatment team and follow up needed. • Greg explored that QI may have to be involved in tracking measures of progress in graph form. Erin to bring this up to Liz and Janelle. • Louise explored use for empty spot in the waiting area where the soda machine used to be and explored if a plant could be installed. It was noted that the plant providers had stated that the area did not receive enough light for a plant. It was agreed that a display for positive feedback forms would be put in that area. It had been suggested previously that this could be a designated wheelchair area, but the area does not provide sufficient space. Instead an area in the main hallway could be used for this purpose. • Berenice reports that there is a work order to upcycle unused cork boards to make room for client art. Reception pending. • Louise explores if a positive sign could be posted reminding parents to tend to their children while at the clinic. Louise to sit down with front staff and see if there is such a sign that could be

	purchased by office max.
Debriefing process	Greg explored having a system in place to alert others of a crisis as well as a debriefing. Berenice reported that at her previous employment "cancel all of my appointments" was the code word for an emergency. This would be a non-alarming code for consumers, but allow staff to be informed that there is an emergency situation.
Training and crisis issues	• Upcoming training with Betsey Knight that would include the security guards that should last 2 hours. • Aldo stressed the importance of having front staff and security guards trained in dealing with crisis interventions. Louise suggested that questions and needs be submitted ahead of time in order to have specific needs addressed. • Nathaniel reported attending a meeting regarding expanding the training to police officers to cover trauma informed care during 5150 crisis interventions. • Juan reported observing a crisis in clinic and explored the need for further training. There was discussion on various alternatives that be used to create a safe environment for all.
Upcoming Webinars	**October 17 at 11am Greg Watson, Berenice Badillo and Mario Martinez to present to learning committee on domain 5 safe and secure environments.**
Next Meeting	Wed at 10/9/13 @ 11:00 AM

Trauma Informed Care: Core Implementation Team Meeting Minutes – October 9, 2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Mario Martinez, Jenelle Singer, Greg Watson, Juan Estrada, Anne Fitzgerald, Aldo Vereo, Erin Springer *Absent:* Nathaniel Gilbert, Louise Zavala, Terry Maxson
Consumer Surveys	Jenelle will send electronic copies to Aldo Aldo will revise the Spanish version to fix grammatical errors Survey intended for open clients to complete every two weeks (not for patients seen for screening) Parents will be encouraged to complete the survey for children who are unable to complete it on their own (general rule: age 11 and younger) Front desk staff (Vicki and Aldo) will begin to distribute surveys next Monday, 10/14 through 10/25 Erin will take completed surveys to BHS 10/31
Staff Assessment Surveys	14 Completed Red=majority disagreed, Orange=half agreed, Green=majority agreed, Yellow=significant number didn't know Focus of areas for development: red and yellow items current initiative will be Domain 3: Trauma Informed Educated Workforce Jenelle will send electronic copies to Aldo to print in color Anne and Greg will discuss the survey at their staff meetings with a focus on self-care and involvement of security and front desk staff There was discussion regarding the limits of changes we can make while also following county policy in regard to some red items (i.e., including a consumer in interviews, staff input regarding program practices and policies).
Positive Comments Display	Greg spoke to HHSA facilities regarding building a base. They will connect him to a carpenter for a bid. Plan: 3-D tree with branches where clients can add a positive comment on a Velcro leaf Considerations: branches will not stick out to be a hazard to anyone walking by, young children will not be able to pull the branches off the tree, cost of different branch options (paper, stiff, bendy)
Other Information	Betsy Knight will provide a training on Trauma Informed Care to support staff Wednesday 10/17 Suggestion: security guards greet patients and ask benign questions to create a safe and secure environment
Upcoming Webinars	**Thursday, October 17, 2013 Safe & Secure Environment 11:00-12:30, Greg, Berenice, and Mario presenting**
Next Meeting	Wednesday, October 23, 2013 at 11:00

Trauma Informed Care: Core Implementation Team Meeting Minutes – October 23, 2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Mario Martinez, Louise Zavala, Greg Watson, Juan Estrada, Anne Fitzgerald, Erin Springer, Aldo Vereo *Absent:* Jenelle Singer, Terry Maxson
Changes to CIT	Jenelle Singer accepted another position and will no longer be working for the County as of 10/28/13 Nathanial Gilbert is no longer with Family Youth Round Table-Greg will meet with 2 new representatives before next CIT meeting on 11/6/13
Consumer Surveys	Distributing through 10/25/13-Aldo reports consumers are completing them, but may just want to be agreeable Prior to survey consumers noticed changes and verbalized to staff---Consider adding interviews with front desk staff as a 'before measure' prior to survey use
Staff Assessment Review	Greg and Anne followed up at their team meetings Discussion regarding staff understanding TIC and relevance of CIT to the clinic-To get the clinic more engaged in TIC, CIT will invite staff to meetings as special guests Greg will update performance appraisal to add TIC
Positive Comments Tree	Rough drawing is complete but need measurements of the space Greg will give the measurements to HHSA facilities to get feedback on how to construct the tree Will need someone to ensure comments added to tree are appropriate once in use If there are negative comments, CIT will address in meetings
Support Staff Training	Betsy Knight lead training for support staff and 2 security guards 10/16/13 which was very eye opening Greg will follow-up with facilities to tint window to minimize institutionalized look Also suggested to add an adhesive border to glass
Webinar Update	Greg, Mario, & Berenice presented for the Safe & Secure Environment webinar. Feedback was very positive.
Restroom	Ursula will place a work order to request hooks in stalls of men's and women's restroom Remove broken maxi pad dispenser in women's restroom and replace with a shelf
Television	Concerns regarding what is playing while also being trauma-informed and respecting consumer's choice—it helps to pass time particularly for walk-ins Add magazines to waiting room Use soothing music and nature DVDs-may want to post a sign regarding policy on television
Next Meeting	Wednesday, November 6, 2013

Trauma Informed Care: Core Implementation Team Meeting Minutes – 11/6/13	
Highlight indicates Action Items	
Attendance	*Present:* Anne Fitzgerald, Helen Hollis, Mario Martinez, Erin Springer, Aldo Vereo, Greg Watson, Louise Zavala *Absent:* Berenice Badillo, Juan Estrada, Terry Maxson
Announcements	Helen Hollis is a new member to TIC Core Team. She works for Family Youth Round Table. Greg attended ACES Study meeting. Focus was on Child Sexual Trauma. See cst.onehealth.com
Positive Comments Tree	County contractors are unavailable to build tree. Berenice and Greg will create tree using another method. Mario offered his carpentry skills to make sure tree is child proof. Mario suggested that Art Therapy Group take the lead in creating tree. Also suggested utilized some fabrics in creating the tree. Helen suggested staff have welcoming comments to help alleviate any pressure of consumers writing comments on tree.
Tint of Windows	Ursula Snowden has received cost estimate of light tint for window. Samples will be reviewed at a later time by TIC Core Team.
Consumer Surveys	Erin will coordinate with QI to work on surveys.
Restrooms	Hooks have been installed to restrooms.
Domains	At next meeting, there will be discussion on other domains to be focused on. Greg will email list of domains to CORE Team.
Upcoming trainings	Sabrena will continue to look for "Seeking Safety" training slots. Aldo suggested classes on self-care. Core Team discussed having a Yoga class during lunch time.
Future Meetings	Wednesday, November 20, 2013, 11 am to 12 pm. Continue meeting Biweekly through April 2014. Louise suggested potluck luncheon meeting with Steering Committee to review TIC Core Team's accomplishments the past year and future goals.

Trauma Informed Care: Core Implementation Team Meeting Minutes – 11/20/2013	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Mario Martinez, Helen Hollis, Erin Springer, Greg Watson, Juan Estrada, Anne Fitzgerald and Terry Maxson. *Absent:* Louise Zavala and Aldo Vereo.
	Helen Hollis provided Newsletters, Wellness Plans and brochures on Parent Advisory Groups from Family Youth Roundtable.
	Update on the "Comments Tree" that will go up in the lobby: Aldo and Mario have done the measurements for a flat tree mounted on the wall. There will be no movable parts, Velcro on the branches and on the "comment leaves". Mario and Berenice will work on a sketch of the tree.
	Consumer Surveys are completed and the compilation list done by Erin was reviewed today. Copies will go to staff, Q I, the Steering Comm. and the Learning Community.
	More discussion took place on the "best television DVD's to utilize in the Waiting Room. Terry brought up making a connection with Mental Health America re this. Anne will follow up and also inquire of Louise and Vickie. Greg will e-mail Sabrena to find out about what other County offices are displaying on their televisions.
	Domain # 3, "A Trauma Informed Educated and Responsive Workforce" will be our focus as we move on in our learning and practice processes. Already, the Children's staff is coordinating with BHS Admin. to identify any clients we serve, who have an active CPS case, for the Katie A. initiative (to be called "Pathways to Well Being" here in SD County BHS). Also several clinical staff and Greg Watson will attend an all- day "Seeking Safety" training in March, 2014. Anne and Greg have attended some of the County's Trauma Guide Team meetings, and we are sending significant links about trauma to our staff frequently.
Upcoming Webinars	
Next Meeting	We., 12/4/2013 at 11:00 AM

Trauma Informed Care: Core Implementation Team Meeting Minutes – 12-4-13	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Greg Watson, Juan Estrada, Anne Fitzgerald, Aldo Vereo, Erin Springer *Absent:* Louise Zavala, Terry Maxson, Mario Martinez
	Anne presented trauma related book "The boy who was raised like a dog", by Dr. Bruce Perry. Bruce Perry will be presenting at Washington DC conference. Anne: involve security guards about receptive environment (RE). Best positive videos for front desk.
	Berenice working on a reception area tree sketch. How to install, materials to use, etc.
	Greg: will follow up with Ursula about window tinting. Greg presented that at all day conference on 12/3/13 the concept of welcoming behavior was presented. This included 3 elements, eye contact, smile, and greeting. The question is how to convey to front desk staff. The expectation would be to smile, greet and eye contact with clients at the clinic. There will be training about this new approach. Greg will look into scheduling receptive environment (RE) training with security guards.
	Aldo: will look into Amazon for positive videos for reception area.
	Erin: working on a time line. Target date to accomplish projects covering domains, etc. Talked about "live well san Diego" video as possible material for reception area.
Upcoming Webinars	**Domain 6 webinar on 12/16/13 at 11:00 AM.**
Next Meeting	12/18/13 @ 11AM

Trauma Informed Care: Core Implementation Team Meeting Minutes –

Highlight indicates Action Items

Attendance	*Present:* Berenice Badillo, Helen Hollis, Holly Jones, Mario Martinez, Louise Zavala, Greg Watson, Juan Estrada, Anne Fitzgerald, Aldo Vereo *Absent:* none
	Greg: Invites all to participate in the conference call on Jan 3. Greg: Performance monitoring tool to be reported again in March, plan to work on it in February to meet deadline.
	Berenice: Provided sketch drawing of 'Positive Comments Tree', Moving right along! Awesome consumer project! Berenice: Announced the consumer art show April 30, 2014 from 9-12
	Greg: Window tinting cannot be done, because of the treatment on the window to make it shatter proof. Looking into other alternatives. Greg: Maintenance is looking at the overhead to see if track lighting is feasible for area where "Positive Comments Tree" would go. Greg: Educate workforce training completed with front desk staff and security guards, Including eye contact, smiling, and welcoming clients.
	Aldo/Anne: Videos were ordered for the front lobby from National Geographic, but books were received.
	Greg: will follow up with east county child welfare to inquire on their feed into their lobby television. Greg: will connect with planning group for the NAMI walk for the may mental health month regarding TIC participation.
Upcoming Webinars	**Final webinar complete. Domain 6.**
Next Meeting	January 8, 2014 @ 11:00am ; January 22, 2014 @ 11:00am

Trauma Informed Care: Core Implementation Team Meeting Minutes – Jan. 8, 2014	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Mario Martinez, Jenelle Singer, Louise Zavala, Greg Watson, Juan Estrada, Anne Fitzgerald, Terry Maxson, Aldo Vereo, Liz Miles, Helen Hollis, Holly Jones and Patricia Fulgencio *Absent:* none
Nat. Consultant Conf.	Greg- The conference call recognized that the Team was covering many of the areas in our recently submitted self-assessment. We are being noticed by others working in the area of TIC.
Consumer Art Show	Berenice- The occasion will celebrate the one year anniversary of the Implementation Teams work. The event will also spotlight the work of individuals in the Clinic Art Group by showing their work. To take place on April 30th, it will include the "Comments Tree". Berenice will provide opportunities for the Team to participate in the preparation.
Positive Comments Tree	Berenice- The tree is being constructed at the Clinic on Fridays during the 10-12 Art Group Meeting. Consumers will be invited to write and place their comments on the tree.
NAMI Walk at Liberty Station	Greg- Date may be May 3rd and will coincide this year with may as Mental Health Month. Greg reported that the TIC Guide Team wants to participate, Greg will follow up.
State Survey (Adults)	Liz Miles shared data from the MHSIP survey of SE CMH Adult programs which had positive client report.
Upcoming Webinars	**Compassion fatigue January 30th at 11:00 AM**
Next Meeting	Jan. 22, 2014

Trauma Informed Care: Core Implementation Team Meeting Minutes – Jan. 22, 2014	
Highlight indicates Action Items	
Attendance	*Present:* Berenice Badillo, Mario Martinez, Louise Zavala, Greg Watson, Juan Estrada, Aldo Vereo, Terry Maxson and Patricia Fulgencio *Absent:* Holly Jones
Trauma Champions Workgroup.	Greg- The workgroup is charged with implementation of Trauma Informed Care for the Health and Human Services Agency. There is a consultant working with the group named Dawn Griffin. She will be scheduling a time to attend one of the Core Implementation Team meetings.
Art Show and Comments Tree.	Berenice- We are still working on the Art Show. The Skeleton for the Positive Comments Tree will be put up on Friday. Mario- People from the community are interested in attending the Art Show.
NAMI Walk at Liberty Station	Greg- Berenice and some members of the art group will be in charge of a mural project at the event. In addition, consumer art will be on display. Southeast Mental Health will also have a table at the event.
Changes in CIT membership	Anne Fitzgerald has changed assignments and will no longer be able to attend the CIT. Diana Cobb will be taking her place as the Program Manager for Southeast Mental Health Children's Program and will participate in the CIT as a part of that role. Helen Hollis will no longer be attending the CIT meetings
Webinar	Compassion fatigue January 30th at 11:00 AM
Next Meeting	**Feb. 05, 2014.**

Attachment D: Trauma Informed Care Timeline

Trauma Informed Care Learning Collaborative Timeline, February 2013-May 2014